FEE BASIS

Version 3.5

USER MANUAL

Supplemental Pages

For

Fee Basis Replacement Project: Phase One - FB*3.5*61

October 2003

Department of Veterans Affairs
Information Systems Center
Albany, New York

PREFACE

This document provides a quick reference guide documenting changes that occurred within VistA Fee Basis Patch 61.

These changes will also be incorporated into the online version of the VistA Fee Basis User Manual following the release of Patch 61.

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INTRODUCTION

The Fee Basis User Manual has been updated to document changes made to VistA Fee for HIPAA compliance. As of October 16, 2003, all Fee Basis programs, as other VA sponsored healthcare programs, are subject to the requirements for HIPAA (Health Insurance Portability and Accountability Act) for Electronic Data Interchange (EDI) claims. To support and supplement the efforts of the Health Administration Center (HAC) in Denver, Colorado to ensure HIPAA compliance for the Fee Basis program, a series of modifications have been made to the VistA Fee software package within VistA.

Effective October 16, 2003, all EDI transaction claims for Fee Basis will be submitted to the HAC. The HAC will receive all of the EDI transactions that pertain to Fee Basis covered veterans. This will include EDI claims (837), EDI authorization requests (278) and EDI eligibility requests (270). The HAC is responsible for generating the response to all EDI transactions including the EDI Electronic EOB (835), EDI Authorization response (278) and EDI Eligibility response (271). EDI claims status inquiries and responses will be also handled by the HAC (276/277). NCPDP Pharmacy EDI transactions will be addressed by the HAC, too.

Though the EDI transactions will be received and initially processed at the HAC, the specified daims adjudication for all electronic claims will be locally managed through VistA Fee and other related VA Systems currently in use. The HAC will forward via Web Screen Displays, the electronic claims data to the appropriate Fee site. The Fee Site Users will print the information, in a HAC/FPPS developed print format, for each electronic claim so that the electronic claim can be entered as an invoice into VistA Fee. The printed FPPS claim document will contain claims data acceptable by VA standards for inclusion in the hard copy batch invoice data used for fiscal vouchering and records storage. Upon final adjudication and payment from Treasury, all associated information regarding the final claim status will return to VistA Fee whereby final adjudication status information will be returned to the HAC FPPS system for generation of the Electronic EOB.

To accommodate this workflow, VistA Fee has been modified to address:

- Necessary identification data associated with the EDI claim as processed into the HAC FPPS system;
- Necessary modifications to support the itemization and specialization of data within the EDI transactions as mandated by HIPAA for EDI claims: and,

- Trigger and produce a file of required information to flow back to the HAC FPPS system via automatic interface to support the generation of the EDI Electronic EOB (835).

This update to the Fee Basis User Manual contains three significant categories of revisions to the user manual documentation for VistA Fee. First, there are revised VistA Fee invoice prompts and edit invoice prompts for all sections of the Fee Basis User Manual, including Civil Hospital, Community Nursing Home, Pharmacy, Medical and Unauthorized Claims, to accommodate the processing of EDI claims in VistA Fee. Second, there are updated versions of specific VistA Fee outputs for each VistA Fee module. And, third, there are new Supervisor menu options added to VistA Fee for Error Management and Interface Management. User Manual documentation for these new menu options is included in this manual update. All of the user manual updates are in response to the changes made to VistA Fee for EDI claims.

Health Systems Design and Development

CIVIL HOSPITAL
Payment Process Menu
Ancillary Contract Hospital Enter Ancillary Payment


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

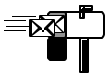
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

 FBAA ESTABLISH VENDOR - required to enter new or edit existing vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

This option is used to enter payments for ancillary services (services other than those included in the DRG) rendered while a patient is in a Contract Hospital for an authorized admission. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

Only authorized Contract Hospital ancillary payments can be entered through this option. All other Fee Basis payments are entered through other payment options. Payment may be made for two or more of the same type of services to the same patient on the same date. You may enter additional payments from a previous invoice (for the same patient) or payments from a new invoice. A new invoice number is assigned automatically, when required.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A. Depending on site parameters at your facility, patient authorization information and vendor demographics may be displayed. Vendor demographics may be edited if you hold the FBAA ESTABLISH VENDOR security key. If there are previous payments to the vendor for the selected patient, a payment history is shown.

You receive a warning when the patient has reached the maximum payment amount allowed for the month of service; or when you have reached 20 lines from the maximum number of payment lines allowed in a batch (set by the Max. # Payment Line Items site parameter).

Example

```
Select Payment menu Option: ENTER Payment


Select FEE BASIS BATCH NUMBER: 1591
  Obligation #: C95003




Select Patient: FEEP
   1   FEEPATIENT,FEE A        3-15-40    405345678           SC VETERAN

   2   FEEPATIENT,FEE B        7-15-40    000003424           NSC VETERAN

   3   FEEPATIENT,MST A        1-20-55    803945832         05-01-01     NSC VET
ERAN
   4   FEEPATIENT,MST B        5-4-30    604324567           SC VETERAN

CHOOSE 1-4: 1  FEEPATIENT,FEE A        3-15-40    405345678           SC VETERAN




FEEPATIENT,FEE A                        Pt.ID: 405-34-5678
1313 MOCKINGBIRD LN                       DOB: MAR 15,1940
HAMPTON                                   TEL: 555-5555
VIRGINIA 23664                         CLAIM #: Not on File
                                        COUNTY: HAMPTON (IC)

Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  SEP 05, 2000
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 60%
 Rated Disabilities: NONE STATED

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ==========================================================================
    No Insurance Information

                ***  Patient has Insurance Buffer entries  ***


Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO




Patient Name: FEEPATIENT,FEE A                        Pt.ID: 405-34-5678
```

Example (Cont.)

```
AUTHORIZATIONS:
   (1) FR: 3/1/2003      VENDOR: Not Specified
       TO: 9/30/2003
                         Authorization Type: Unknown
           DX: test
               test2
               test3
       County: HAMPTON (IC)             PSA: Unknown

           REMARKS:
              TEST

   (2) FR: 2/9/2003      VENDOR: Not Specified
       TO: 5/20/2003
                         Authorization Type: Outpatient - Short Term
           Purpose of Visit: CHIROPRACTIC CARE
           DX:
       County: HAMPTON (IC)             PSA: ALBANY

Enter RETURN to continue or '^' to exit: ^




Enter a number (1-28): 2
AUTHORIZATION REMARKS:
  1>No remarks
EDIT Option:
DX LINE 1:
DX LINE 2:
DX LINE 3:


Select FEE BASIS VENDOR NAME: ACUTE   CARE SPECIALISTS INC    341339182  DOCTOR
OF MEDIC
          2620 RIDGEWOOD RD  100
          TEST
          AKRON, OH  44313    TEL. #:  1-800-837-0703

                      ***  VENDOR DEMOGRAPHICS  ***

        Name:  ACUTE CARE SPECIALISTS INC       ID Number: 341339182
     Address:  2620 RIDGEWOOD RD  100          Specialty: PHYSICIANS-NONDIPLOM
 Address [2]:  TEST
        City:  AKRON                                Type: PHYSICIAN
       State:  OHIO                    Participation Code: DOCTOR OF MEDICINE
         ZIP:  44313                   Medicare ID Number: 333333
      County:  ADAMS                                Chain:
       Phone:  1-800-837-0703
         Fax:
 Type (FPDS):  SMALL BUSINESS
 Austin Name:  ACUTE CARE SPECIALISTS INC
 Last Change                                 Last Change by Station 500
   TO Austin:  5/18/99                         FROM Austin:  5/18/99
Want to Edit data? NO//
```

Example (Cont.)

```
Patient Name: FEEPATIENT,FEE A            SSN: 405345678

  VENDOR: ACUTE CARE SPECIALISTS INC
     2620 RIDGEWOOD RD  100
     AKRON, OHIO   44313
          ('*' Reimb. to Patient  '+' Cancel. Activity   '#' Voided Payment)
 SVC DATE  CPT-MODIFIER       AMT CLAIMED AMT PAID  CODE   INVOICE # BATCH #
-------------------------------------------------------------------------------

  03/07/03  90819             $   10.00   $    9.00 1      2200      1600
  03/04/03  17304             $  100.00   $   90.00 1      2178      1629
  03/04/03  10180             $   50.00   $   50.00        2178      1629
  03/03/03  11200-50          $     .09   $     .09        2191      49
                -51
                -52
* 02/19/03  99284             $  150.00   $   86.62 1      2172      1629
  11/07/02  99284             $ 1000.00   $     .00 4      2168      1600
  08/27/02  99025             $   50.00   $   50.00        2162      1600
  08/26/02  G0153             $   20.00   $   20.00        2153      1591
  08/12/02  10060-23          $    2.22   $    2.22        2171      1400
  08/12/02  10060-23          $     .25   $     .00 4      2175      1400
  12/05/01  90801             $   20.00   $   20.00        2050      1549
  12/05/01  33315-26          $   40.00   $   40.00        2050      1549
Enter RETURN to continue or '^' to exit: ^

Want a new Invoice number assigned? YES// <RET>

Invoice # 2214 assigned to this Invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): T-2  (APR 27, 2003)


Enter Vendor Invoice Date: T-4  (APR 25, 2003)
PATIENT ACCOUNT NUMBER: 4753822
Is this an EDI Claim from the FPPS System? YES
FPPS Claim ID: 1234

Will any line items in this invoice be for contracted services? No// YES


Date of Service: 3/10/2003   MAR 10, 2003..

$ 3 for travel already entered for this date of service

Total already paid on ID Card for month:   $ 0   Maximum allowed: $ 125
Total already paid on All/Other for month: $ 140

SITE OF SERVICE ZIP CODE: 44313// 44313

Select Service Provided: 98940       CHIROPRACTIC MANIPULATION

Current list of modifiers: none
Select CPT MODIFIER: <RET>

Major Category: MEDICINE
  Sub-Category: CHIROPRACTIC MANIPULATIVE TREATMENT
      Procedure: 98940   CHIROPRACTIC MANIPULATION
```

Example (Cont.)

```
                    Detail Description
                    ==================

CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

CODE TEXT MAY BE INACCURATE
Is this correct? YES// <RET>
       CHIROPRACTIC MANIPULATION
REVENUE CODE: <RET>
UNITS: 1// <RET>
FPPS LINE ITEM: 1
Is this line item for a contracted service? No//   NO
Select PLACE OF SERVICE: 11       OFFICE
AMOUNT CLAIMED: 25
  Fee schedule amount is $23.55 from the 2003 RBRVS FEE SCHEDULE
AMOUNT PAID: 23.55// <RET>
Up to 2 adjustment reasons can be specified.
Select ADJUSTMENT REASON: 119  Benefit maximum for this time period has been reached.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 1.45// 1.00
Select ADJUSTMENT REASON: 42  Charges exceed our fee schedule or maximum allowable
amount.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 0.45// <RET>
PRIMARY DIAGNOSIS: 724.1  724.1     PAIN IN THORACIC SPINE
         ...OK? Yes//   (Yes)

HCFA TYPE OF SERVICE: <RET>
SERVICE CONNECTED CONDITION?: Y  (YES)
REMITTANCE REMARK: MA125  Per legislation governing this program, payment constitutes
payment in full.
REMITTANCE REMARK: <RET>

Select Service Provided:


Date of Service:

Invoice: 2214 Totals $ 23.55




Select Patient:


Select FEE BASIS BATCH NUMBER:
```

CIVIL HOSPITAL
Payment Process Menu
Complete a Payment

 New Prompts:

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

 Required Prompt!

DRG Weight: DRG weight is not a new prompt; however, data entry of this field is now <u>required</u> to meet HIPAA regulations, instead of being optional as in previous releases of VistA Fee Basis.

To answer the prompt, type a number between 0 and 999.9999, using up to 4 decimal digits. Please note that the VistA Fee Basis System user must enter the decimal point – this is not automatically entered.

Introduction

The Complete a Payment option is used to enter the amount paid for a Contract Hospital payment received from the Austin Pricer. The batch status of invoices entered at this option must be FORWARDED TO PRICER. This option also gives you the opportunity to reject items from the Austin Pricer.

Example

```
Select Payment Process Menu Option: complete a Payment

Select FEE BASIS BATCH NUMBER: 22132       C27042
Would you like to reject any invoices from the pricer? NO// n  NO


Select Patient: FeePatient, milES H    FEEPATIENT, MILES H        7-17-25    5612
82421    YES    40%    SC VETERAN    WL/LL/
 Enrollment Priority: GROUP 2    Category: IN PROCESS    End Date:
    64077               FEEPATIENT,MILES H


                              INVOICE DISPLAY
                             =================

Veteran's Name                                    Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

FEEPATIENT,MILES H  561-28-2421               Feemh092203
    CHARTER HOSPITAL OF CORONA               952685883        64077
    12345678      ALL              06/14/03   6/14/03    04/25/03   09/12/03
    14500.00     0.00        23                  0.00
    Dx: 670.04
    Proc: 98.03
    Associated 7078: C27042.0352
    Batch #: 22132                     Date Finalized:



NVH PRICER AMOUNT: 1233.24
AMOUNT PAID: 1202.44
Select ADJUSTMENT REASON: 42    Charges exceed our fee schedule or maximum
              allowable amount.
ADJUSTMENT GROUP: oa    Other adjustments
ADJUSTMENT AMOUNT: 13297.56// 13297.56 <RET>
DISCHARGE DRG: 1  DRG1
DRG WEIGHT: 1.0234

Current list of Remittance Remarks: none

Select REMITTANCE REMARK: ma125    Per legislation governing this program, payment
              constitutes payment in full.

Current list of Remittance Remarks: MA125,

Select REMITTANCE REMARK: <RET>

Select FEE BASIS BATCH NUMBER:  <RET>
```

CIVIL HOSPITAL
Payment Process Menu
Edit Ancillary Payment

 New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

 Only holders of the FBAASUPERVISOR security key may edit payments from batches that have been released by a supervisor.

Introduction

The Edit Ancillary Payment option is used to edit data for a previously entered invoice for ancillary services rendered to a Contract Hospital patient.

Payments from batches that have been transmitted cannot be edited.

Example

```
Select Payment menu Option: EDit Payment

Select FEE BASIS PAYMENT PATIENT:    FEEPATIENT,FEE A

Select VENDOR:    ACUTE CARE SPECIALISTS INC
Date of Service: 3/10/2003   MAR 10, 2003..
Select SERVICE PROVIDED: 98940       CHIROPRACTIC MANIPULATION
Service Provided: 98940//        CHIROPRACTIC MANIPULATION

Current list of modifiers: none
Select CPT MODIFIER:
REVENUE CODE: <RET>
UNITS: 1// <RET>
SITE OF SERVICE ZIP CODE: 44313// <RET>
Is this line item for a contracted service? No//   NO
PLACE OF SERVICE: OFFICE (11)// <RET>
AMOUNT CLAIMED: 25// <RET>
  Fee schedule amount is $23.55 from the 2003 RBRVS FEE SCHEDULE
AMOUNT PAID: 23.55// <RET>
Up to 2 adjustment reasons can be specified.
Select ADJUSTMENT REASON: 119// <RET>
  ADJUSTMENT GROUP: CO// <RET>
  ADJUSTMENT AMOUNT: 1.00// <RET>
Select ADJUSTMENT REASON: 42// <RET>
  ADJUSTMENT GROUP: CO// <RET>
  ADJUSTMENT AMOUNT: 0.45// <RET>
Is this an EDI Claim from the FPPS System? YES// <RET>
FPPS Claim ID: 1234// <RET>
FPPS LINE ITEM: 1// <RET>
Exit ('^') allowed now
PRIMARY SERVICE FACILITY: ALBANY// <RET>
OBLIGATION NUMBER: C95003// <RET>
DATE CORRECT INVOICE RECEIVED: APR 27,2003// <RET>
VENDOR INVOICE DATE: APR 25,2003// <RET>
PATIENT ACCOUNT NUMBER: 4753822// <RET>
PATIENT TYPE CODE: MEDICAL// <RET>
TREATMENT TYPE CODE: SHORT TERM FEE STATUS// <RET>
PURPOSE OF VISIT: CHIROPRACTIC CARE// <RET>
PRIMARY DIAGNOSIS: 724.1// <RET>
HCFA TYPE OF SERVICE: <RET>
SERVICE CONNECTED CONDITION?: YES// <RET>
REMITTANCE REMARK: MA125// <RET>
REMITTANCE REMARK: <RET>

Select SERVICE PROVIDED:


Select FEE BASIS PAYMENT PATIENT:
```

CIVIL HOSPITAL
Payment Process Menu
Enter Payment


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

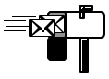
FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.


FBAA ESTABLISH VENDOR - required to enter new or edit existing vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.


A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.


New insurance information may be uploaded into IB files through this option.

Introduction

The Enter Invoice/Payment option is used to enter new Contract Hospital payments. Only authorized hospital invoices/payments may be entered through this option. All other Fee Basis payments are entered through other payment options. The Invoice Edit option must be used to make changes or adjustments to existing payments.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

If the vendor is exempt from the Austin Pricer, you will be prompted to enter the amount paid, and the payment will not be sent to the pricer.

Every prompt should be answered. Failure to enter a response or entering a <RET> or an up-arrow <^> at any prompt may result in an incomplete entry or deletion of the entire entry.

Example

```
Select Payment Process Menu Option: ENter Invoice/Payment


Select Patient:    FEEPATIENT,FEE A



FEEPATIENT,FEE A                        Pt.ID: 405-34-5678
1313 MOCKINGBIRD LN                       DOB: MAR 15,1940
HAMPTON                                   TEL: 555-5555
VIRGINIA 23664                         CLAIM #: Not on File
                                        COUNTY: HAMPTON (IC)

Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  SEP 05, 2000
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 60%
 Rated Disabilities: NONE STATED

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information
                 ***  Patient has Insurance Buffer entries  ***
Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO
Patient Name: FEEPATIENT,FEE A                          Pt.ID: 405-34-5678

AUTHORIZATIONS:
   (1) FR: 4/9/2003      VENDOR: BETH ISRAEL HOSPITAL - 042103881
       TO: 4/9/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: AUTHORIZED NON-VA HOSPITAL CARE FOR SC COND.
           DX: ADMIT DIAF
       County: HAMPTON (IC)             PSA: ALBANY


           REMARKS:
              Hospitalization and Professional care necessary until
              the patients' condition is stabilized or improved
              enough to permit transfer without hazard to a VA or
              other Federal facility for continued treatment.

   (2) FR: 8/1/2002      VENDOR: MEMORIAL HOSPITAL - 146002568A
       TO: 8/13/2002
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: AUTHORIZED NON-VA HOSPITAL CARE FOR SC COND.
           DX: DIAG
```

```
      County: HAMPTON (IC)            PSA: VISN 2
           >> DELETE MRA SENT TO AUSTIN ON -  >>

Enter RETURN to continue or '^' to exit: ^

Enter a number (1-18): 1

Patient Name: FEEPATIENT,FEE A                  Pt.ID: 405-34-5678

                     ***  VENDOR DEMOGRAPHICS  ***

       Name:  BETH ISRAEL HOSPITAL             ID Number: 042103881
    Address:  330 BROOKLINE AVE #207           Specialty:
       City:  BOSTON                                Type: PRIVATE HOSPITAL
      State:  MASSACHUSETTS           Participation Code: NON-VA HOSPITAL
        ZIP:  02215                   Medicare ID Number: 000000
     County:  MIDDLESEX                           Chain:
      Phone:  617-7352000
        Fax:
 Type (FPDS):
 Austin Name:  BETH ISRAEL HOSP NUR SV
 Last Change                                Last Change
   TO Austin:                                 FROM Austin:  11/18/93


Select FEE BASIS BATCH NUMBER:    1648     C95003

Invoice # 2215 assigned to this Invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): T-3  (APR 26, 2003)
Enter Vendor Invoice Date: T-4  (APR 25, 2003)
PATIENT CONTROL NUMBER: 4737123
Is this an EDI Claim from the FPPS system? YES
FPPS CLAIM ID: 2345
FPPS LINE ITEM: ALL
Is this line item for a contracted service? No//   NO
DISCHARGE TYPE CODE: ?
    Answer with FEE BASIS DISPOSITION CODE, or NUMBER, or NAME
   Choose from:
   1            TO HOME OR SELF CARE
   2            TO ANOTHER SHORT-TERM FACILITY
   3            TO SKILLED NURSING FACILITY
   4            TO INTERMEDIATE NURSING FACILITY
   5            TO ANOTHER TYPE OF FACILITY
   6            TO HOME FOR HOME HEALTH SERVICES
   7            LEFT AGAINST MEDICAL ADVICE
   8            DIED
   9            STILL A PATIENT

DISCHARGE TYPE CODE: 1  TO HOME OR SELF CARE
COVERED DAYS: 1// <RET>
BILLED CHARGES: 400
AMOUNT CLAIMED: 400
PAYMENT BY MEDICARE/FED AGENCY: N  (NO)
ICD1:    724.1     PAIN IN THORACIC SPINE
         ...OK? Yes//   (Yes)
ICD2:
PROC1:
```

CIVIL HOSPITAL
Payment Process Menu
Edit Payment


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Edit Payment option is used to edit data for a previously entered Medical Fee payment. You may also delete an entire existing payment entry or delete individual data items, other than required fields. You cannot edit payments in batches that have been finalized.

Example

```
Select Payment Process Menu Option: invoice Edit

Select FEE BASIS BATCH NUMBER: 22097       C27042

Select FEE BASIS INVOICE NUMBER:  64075

                               INVOICE DISPLAY
                              =================

Veteran's Name                                    Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                              Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

HAASEL,DANNY LEE   311-58-5197                   hasdl0603
    CHARTER OAK BHS                          95462347001      64075
    8765          ALL              06/14/03   6/14/03    01/02/03   09/05/03
    50000.00     457.82      246       35        49542.18       MA125,N1
    Dx: 250.02
    Proc: 34.03
    Associated 7078: C27042.0147
    Batch #: 22097                      Date Finalized:

INVOICE DATE RECEIVED: JUN 14,2003// <RET>
VENDOR INVOICE DATE: JUN 14,2003// <RET>
PATIENT CONTROL NUMBER: hasdl0603// <RET>
Is this an EDI Claim from the FPPS system? YES// <RET>
FPPS CLAIM ID: 8765// 8765 <RET>
Does this VistA invoice cover all line items on the FPPS Claim? YES// <RET>
Is this line item for a contracted service? No//   NO <RET>
DISCHARGE TYPE CODE: TO HOME OR SELF CARE// <RET>
COVERED DAYS: 246// 3
BILLED CHARGES: 56700// <RET>
PAYMENT BY MEDICARE/FED AGENCY: NO// <RET>
AMOUNT CLAIMED: 50000// <RET>
AMOUNT PAID: 457.82// <RET>
ADJUSTMENT REASON: 35// 35    Benefit maximum has been reached.  <RET>
ADJUSTMENT GROUP: CO// CO    Contractual Obligations  <RET>
ADJUSTMENT AMOUNT: 49542.18// 49542.18   <RET>
ICD1: 250.02// <RET>
ICD2:
PROC1: 34.03// <RET>
PROC2:
Current list of Remittance Remarks: N1, MA125,

Select REMITTANCE REMARK:
```

CIVIL HOSPITAL
Batch Main Menu - CH
List Items in Batch

New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Introduction

The List Items in Batch option is used to view all payment records in a selected batch. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

EXAMPLE #1

```
Patient Name ('*' Reimbursement to Veteran   '+' Cancellation Activity)
            ('#' Voided Payment)                          Batch Number
   Vendor Name                              Vendor ID   Invoice #  Dt Inv Rec'd
   FR DATE    TO DATE  CLAIMED   PAID    ADJ CODE
================================================================================


FEEPATIENT,FEE A                  405-34-5678             1678
   BETH ISRAEL HOSPITAL                        042103881    2314        7/8/03
    FPPS Claim ID: 4300   FPPS Line: 1-5
    04/09/03 04/09/03 100.00     50.00       B13        Discharge DRG1
    Dx: 724.1

               Invoice #: 2325   Totals: $ 129.66
```

EXAMPLE #2

```
Patient Name ('*' Reimbursement to Veteran   '+' Cancellation Activity)
             ('#' Voided Payment)                          Batch Number
   Vendor Name                                Vendor ID   Invoice #  Dt Inv Rec'd
   FR DATE    TO DATE  CLAIMED   PAID    ADJ CODE
================================================================================


FEEPATIENT,FEE A                   405-34-5678              1555
   AMESBURY HOSPITAL                          046001067    2060        7/31/01
    07/31/01 07/31/01  50.00      2.00       5
    Dx: V65.0

FEEPATIENT,FEE A                   405-34-5678              1555
   AMESBURY HOSPITAL                          046001067    2061        7/31/01
    07/31/01 07/31/01  30.00     30.00       5
    Dx: 282.5
```

CIVIL HOSPITAL
Output Menu
Check Display

New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example #1

```
                    PAYMENT HISTORY FOR CHECK # 35271790
                    -----------------------------------              Page: 1

                      FEE PROGRAM:  CIVIL HOSPITAL
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   From Date   To Date                                    Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  MEMORIAL HOSPITAL               VENDOR ID:  146002568A

Patient:  ALDRICH,JOHN D.                   Patient ID:  333-33-3333
   4/13/90     4/18/90                                    669      147
        10.00       10.00            0.00
    >>>Check # 35271790  Date Paid:  8/26/94<<<
```

Example #2

```
Select Output Menu Option: check Display

Select Check Number: 22836

DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


                   PAYMENT HISTORY FOR CHECK # 22836
                   ---------------------------------                 Page: 1

                     FEE PROGRAM:  CIVIL HOSPITAL
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   From Date   To Date                                    Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  CHARTER OAK BHS                  VENDOR ID:  95462347001

Patient:  HAASE,DENNIS LEE              Patient ID:  311-58-5197
   8/27/03     8/27/03                                  21901    63822
   267,000.00      267.00   42        266733.00
            FPPS Claim ID: 123          FPPS Line Item: ALL
    >>>Check # 22836  Date Paid:  9/7/03<<<


Enter RETURN to continue or '^' to exit:

Select Check Number:
```

CIVIL HOSPITAL
Payment Menu
Invoice Display


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.


Displays which include line item information have been modified to include check information, date paid, and/or check cancellation information, when applicable. Line items that had previously been cancelled are annotated with a plus sign (+).

Introduction

The Invoice Display option is used to view or print detailed line items associated with a selected Civil Hospital invoice.

NOTE: Although you may view and print both Civil Hospital and Contract Nursing Home invoices with this option, it should be used to view and print Civil Hospital invoices only.

EXAMPLE #1

```
                                INVOICE DISPLAY
                               =================

Veteran's Name                                      Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

DOUGLAS,BOB  123-23-2323                            TESTPCN1
    GOOD TIME,NURSING HOME INC.                  141509755a       2315
                                     07/08/03   7/8/03     06/01/03   06/30/03
    100.00       30.00       29        6          70.00          MA125,N45

    Associated 7078: X95003.0004
    Batch #: 1675                        Date Finalized:
```

EXAMPLE #2

```
                                INVOICE DISPLAY
                               =================

Veteran's Name                                      Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

FEEPATIENT,FEE A  405-34-5678                       TESTPCN
    BETH ISRAEL HOSPITAL                         042103881        2314
    4300          1-5              07/08/03   7/8/03     04/09/03   04/09/03
    100.00       50.00       1         B13       50.00          MA125
    Dx: 724.1
    Associated 7078: C95003.0079
    Batch #: 1678                        Date Finalized:
```

EXAMPLE #3

```
                                INVOICE DISPLAY
                               =================

Veteran's Name                                      Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

BEE,BUMBLE  343-22-2999
    SEAL POINT MEDICAL CNH                       444444005Z       1499
                                     10/02/93   10/1/93    09/01/93   09/05/93
    40.00        30.00                4         10.00

    >>>Check # 102  Date Paid:  5/23/94  Interest: 0.88<<<
    Associated 7078: C00009.0045
*    Batch #: 966                        Date Finalized:
```

CIVIL HOSPITAL
Output Menu
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction:

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

EXAMPLE

```
Select Output Main Menu – CH Option: FPPS Claim Inquiry
FPPS CLAIM ID: 9809

FPPS Claim Inquiry for ID: 9809                       SEP 11,2003
Page 1
-------------------------------------------------------------------------------
Inpatient (CH) Invoice: 63757
Enter RETURN to continue or ^ to exit: ^
```

CIVIL HOSPITAL
Payment Menu
Patient Re-imbursement for Ancillary Services


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

. *Adjustment Reason:* Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

FBAA ESTABLISH VENDOR - required to enter new vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

New insurance information may be uploaded into IB files through this option.

Introduction

The Patient Reimbursement for Ancillary Services option is used to reimburse a patient for ancillary services paid for by the patient. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

The optional CPT MODIFIER prompt allows you to break down services provided to the modifier level.

After the amount claimed is entered, two fee schedules for outpatient services are checked by the software. The system first checks the RBRVS (Resource Based Relative Value Scale) physician fee schedule. If the service is not covered by the RBRVS fee schedule, the system then checks the site-specific VA fee schedule. (This fee schedule is based on payments made during the previous fiscal year by the site and is computed as the 75th percentile of the amount claimed if there where eight or more payments made for that service.) If a fee schedule amount cannot be obtained from either of these fee schedules, you will see the message "Unable to determine a FEE schedule amount."

Displays, which include line item information, include check information, date paid, and/or check cancellation information. Line items that had previously been cancelled are annotated with a plus sign (+).

Example

```
Select Payment Process Menu Option: PATient Reimbursement for Ancillary Services


Select FEE BASIS BATCH NUMBER: 22096
  Obligation #: C27042




Select Patient: gabart, melita  GABART,MELITA      1-10-25    575285105    YES    10%
   SC VETERAN    LL/SD/        **ADVANCE DIRECTIVE - NO 7/22/03**
 Enrollment Priority: GROUP 3    Category: IN PROCESS    End Date:



GABART,MELITA                          Pt.ID: 575-28-5105
10001 JJJJJJO DR                         DOB: JAN 10,1925
VICTORVILLE                              TEL: 760 245-1689
CALIFORNIA 92929                      CLAIM #: 16076516
                                       COUNTY: SAN BERNARDINO

Primary Elig. Code: SC LESS THAN 50%  --  VERIFIED  OCT 31, 1989
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 10%
 Rated Disabilities: DEGENERATIVE ARTHRITIS (10%-SC)
                     SCARS (0%-SC)
                     DUODENAL ULCER (0%-SC)
                     VARICOSE VEINS (0%-SC)

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ============================================================================
    No Insurance Information

Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO



Patient Name: GABART,MELITA                                Pt.ID: 575-28-5105

AUTHORIZATIONS:
   (1) FR: 8/5/2003      VENDOR: CHARTER OAK BHS - 95462347001
       TO: 8/7/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: HOSPICE CARE (INPT.) FEE BASIS AUTHORITY (CFR 17.50
b)
           DX: psychosis
       County: SAN BERNARDINO          PSA: ATWATER

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
```

```
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.


Enter RETURN to continue or '^' to exit:


Patient Name: GABART,MELITA                              Pt.ID: 575-28-5105
   (2) FR: 6/27/2003     VENDOR: LOMA LINDA UNIV MED CENTER - 95352267901
       TO: 7/7/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: EMERG. NON-VA CARE (INPT/OPT) FOR VET. REC. INPT. C
ARE IN VAMC
           DX: stroke
               hysteria
       County: SAN BERNARDINO           PSA: LOMA LINDA

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.


   (3) FR: 3/1/2003      VENDOR: CHARTER OAK BHS - 95462347001
       TO: 9/5/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: UNAUTHORIZED NON-VA HOSPITAL CARE, SC OR NSC COND
           DX: pschosis
       County: SAN BERNARDINO           PSA: FRESNO

Enter RETURN to continue or '^' to exit:


Patient Name: GABART,MELITA                                Pt.ID: 575-28-5105

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.




Enter a number (1-3): 3

Patient:  GABART,MELITA

Patient's Permanent address:
  Address Line 1: 10001 JJJJJJO DR
  City:           VICTORVILLE
  State:          CALIFORNIA
  Zip:            92929
  County          SAN BERNARDINO
```

```
Want to edit Permanent Address data? No//   NO

Want to add Confidential Address data? No//   NO
AUTHORIZATION REMARKS:
HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED UNTIL THE
PATIENT'S CONDITION IS STABILIZED OR IMPROVED ENOUGH FOR TRANSFER,
WITHOUT HAZARD, TO THIS OR ANOTHER VA FACILITY FOR CONTINUED CARE.
PAYMENT FOR HOSPITAL SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL CONSTITUTE PAYMENT IN
FULL.

  Edit? NO// <RET>
DX LINE 1: pschosis// <RET>
DX LINE 2:
DX LINE 3:


Select FEE BASIS VENDOR NAME: nancy a jones
     1   NANCY A JONES D O              330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112

     2   NANCY A JONES DO               330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112

CHOOSE 1-2: 1  NANCY A JONES D O        330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112



Patient Name: GABA,MELY                          Pt.ID: 575-28-5105

                      ***  VENDOR DEMOGRAPHICS  ***

        Name:  NANCY A JONES D O                ID Number: 330663259
     Address:  16003 TUSCOLA ROAD               Specialty: PHYSICIANS-NONDIPLOM
 Address [2]:  SUITE H
        City:  APPLE VALLEY                          Type: PHYSICIAN
       State:  CALIFORNIA             Participation Code: DOCTOR OF MEDICINE
         ZIP:  92307                  Medicare ID Number:
      County:  SAN BERNARDINO                    Chain:
       Phone:  619 946-2112
         Fax:
 Type (FPDS):
 Austin Name:  N A JONES DO
 Last Change                                Last Change by Station 605
   TO Austin:  3/25/96                        FROM Austin:  4/1/96
Want to Edit data? NO// <RET>


Vendor has no prior payments for this patient

Want a new Invoice number assigned? YES// y  YES

Invoice # 64041 assigned to this Invoice
```

```
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): t-20  (AUG 26, 2003)

Enter Vendor Invoice Date: t-20  (AUG 26, 2003)
PATIENT ACCOUNT NUMBER: 123gaba987
Is this an EDI Claim from the FPPS system? y  YES
FPPS CLAIM ID: 43215


Date of Service: t-31   AUG 15, 2003

SITE OF SERVICE ZIP CODE: 92307// <RET>

Select Service Provided: 10121       REMOVE FOREIGN BODY

Current list of modifiers: none
Select CPT MODIFIER: <RET>

Major Category: SURGERY
  Sub-Category: INTEGUMENTARY SYSTEM
      Procedure: 10121   REMOVE FOREIGN BODY

                   Detail Description
                   ==================
INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED
Is this correct? YES// <RET>
       REMOVE FOREIGN BODY
REVENUE CODE: 222       TECH SUPPORT CHG     TECHNICAL SUPPPORT CHARGE
UNITS PAID: 1// <RET>
FPPS LINE ITEM: 2
Select PLACE OF SERVICE: 11       OFFICE
AMOUNT CLAIMED: 654
  Fee schedule amount is $216.74 from the 2002 RBRVS FEE SCHEDULE

AMOUNT PAID: 216.74//215

Current list of Adjustments: none
Select ADJUSTMENT REASON: 35    Benefit maximum has been reached.
ADJUSTMENT GROUP: co    Contractual Obligations
ADJUSTMENT AMOUNT: 439.00// 400

Current list of Adjustments:  Code: 35      Group: CO   Amount: $400.00

Select ADJUSTMENT REASON: 42    Charges exceed our fee schedule or maximum
               allowable amount.
ADJUSTMENT GROUP: oa    Other adjustments
ADJUSTMENT AMOUNT: 39.00// 39.00
HCFA TYPE OF SERVICE:
SERVICE CONNECTED CONDITION?: y  (YES)

Current list of Remittance Remarks: none

Select REMITTANCE REMARK: N1
     1   N1    You may appeal this decision in writing within
               the required time limits following receipt of
               this notice.
     2   N102    This claim has been denied without reviewing the
               medical record because the requested records were
               not received or were not received timely
     3   N11    Denial reversed because of medical review.
```

```
     4   N14    Payment based on a contractual amount or
                agreement, fee schedule, or maximum allowable
                amount.
     5   N18    Payment based on the Medicare allowed amount.
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  N1  You may appeal this decision in writing within
                the required time limits following receipt of
                this notice.

Current list of Remittance Remarks: N1,

Select REMITTANCE REMARK: ma125  Per legislation governing this program, payment
                constitutes payment in full.

Current list of Remittance Remarks: N1, MA125,

Select REMITTANCE REMARK: <RET>

Select Service Provided: <RET>


Date of Service: <RET>

Invoice: 64041 Totals $ 350.00
```

CIVIL HOSPITAL - ANCILLARY
Batch Main Menu - CH
List Items in Batch

New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The List Items in Batch option is used to view all payment records in a selected batch. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

Example

```
Patient Name ('*' Reimbursement to Patient   '+' Cancellation Activity)
             ('#' Voided Payment)                          Batch #  Voucher Date
   Vendor Name                            Vendor ID  Invoice #     Date Rec'd.
    SVC DATE  CPT-MOD   SERVICE PROVIDED              FPPS CLAIM  FPPS LINE
    CLAIMED      PAID         ADJ CODE   ADJ AMOUNT
================================================================================


FEEPATIENT,MST B                   604-32-4567            1692     7/12/03
   ALPINE NURSING HOME                        521591700    2322        7/12/03
    11/15/02  77300     RADIATION THERAPY DOSE PLAN   32100       2
    150.00        80.74       4,B13      50.00,19.26

               Invoice #: 2322   Totals: $ 80.74
```

```
FEEPATIENT,MST B                    604-32-4567            1692     7/12/03
   ACUTE CARE SPECIALISTS INC              341339182    2324         7/12/03
    11/20/02  99361     PHYSICIAN/TEAM CONFERENCE     1            4
    100.00        80.00       B13        20.00
    >>>Check # 81212127  Date Paid:  7/17/03<<<

               Invoice #: 2324   Totals: $ 80.00

FEEPATIENT,MST B                    604-32-4567            1692     7/12/03
   ACUTE CARE SPECIALISTS INC              341339182    2325         7/12/03
    11/15/02  40830-26  REPAIR MOUTH LACERATION       50432       1
                  -53
    200.00       129.66       4,B13      20.34,50.00
    >>>Check # CC212127  Date Paid:  7/14/03<<<

               Invoice #: 2325   Totals: $ 129.66
```

CIVIL HOSPITAL - ANCILLARY
Outputs Main Menu
Check Display


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example #1

```
                    PAYMENT HISTORY FOR CHECK # CC212127
                    -----------------------------------              Page: 1

                      FEE PROGRAM:  OUTPATIENT
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   Svc Date  CPT-MOD   Rev.Code                            Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  ACUTE CARE SPECIALISTS INC       VENDOR ID:  341339182

Patient:  FEEPATIENT,MST B             Patient ID:  604-32-4567
   11/15/02  40830-26  110                                1692     2325
                  -53
       200.00      129.66   4,B13     20.34,50.00
            FPPS Claim ID: 50432        FPPS Line Item: 1
    >>>Check # CC212127  Date Paid:  7/14/03<<<
```

Example #2

```
                    PAYMENT HISTORY FOR CHECK # 81212127
                    -----------------------------------              Page: 1

                      FEE PROGRAM:  OUTPATIENT
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   Svc Date  CPT-MOD   Rev.Code                            Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  ACUTE CARE SPECIALISTS INC       VENDOR ID:  341339182

Patient:  FEEPATIENT,MST B             Patient ID:  604-32-4567
   11/20/02  99361     190                                1692     2324
       100.00       80.00   B13       20.00
            FPPS Claim ID: 1            FPPS Line Item: 4
    >>>Check # 81212127  Date Paid:  7/17/03<<<
```

Example #3

```
                    PAYMENT HISTORY FOR CHECK # 1212127
                    ----------------------------------               Page: 1

                      FEE PROGRAM:  OUTPATIENT
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   Svc Date  CPT-MOD   Rev.Code                            Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  ACUTE CARE SPECIALISTS INC       VENDOR ID:  341339182

Patient:  FEEPATIENT,MST B             Patient ID:  604-32-4567
*  4/4/01    99213                                         1308     1901
        80.00       48.84   1         31.16
    >>>Check # 1212127  Date Paid:  7/16/03<<<
*  4/11/01   99213-52                                      1308     1901
        20.00       20.00             0.00
    >>>Check # 1212127  Date Paid:  7/16/03<<<
```

CIVIL HOSPITAL
Outputs Main Menu
Ancillary Contract Hospital Invoice Display


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.
FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.
Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Invoice Display option is used to view or print detailed line items associated with a selected Outpatient Medical invoice.

Example #1

```
Invoice Number: 2325          Vendor Name: ACUTE CARE SPECIALISTS INC
  Date Received: 07/12/03        Invoice Date: 7/12/03
  FPPS Claim ID: 50432           Patient Account #:
         ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
PATIENT                          SVC DATE  CPT-MOD /REV  BATCH NO. VOUCHER DATE
   FPPS LINE  AMT CLAIMED AMT PAID  UNITS  ADJ CODE  ADJ AMT         REMIT RMK
================================================================================

FEEPATIENT,MST B                 11/15/02  40830-26/110  1692      7/12/03
                                                  -53
   1          $  200.00   $  129.66  2     4,B13     $20.34,50.00    M17,M1
```

Example #2 (Non-EDI invoice)

```
Invoice Number: 1900          Vendor Name: PUCKETT LAB
  Date Received: 05/09/01        Invoice Date: 5/5/01
  FPPS Claim ID: N/A             Patient Account #:
         ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
PATIENT                          SVC DATE  CPT-MOD /REV  BATCH NO. VOUCHER DATE
   FPPS LINE  AMT CLAIMED AMT PAID  UNITS  ADJ CODE  ADJ AMT         REMIT RMK
================================================================================

FEEPATIENT,MST A                 3/14/01   11200         1307      5/9/01
              $   45.00   $   45.00                  $0.00

FEEPATIENT,MST A                 3/22/01   11200         1307      5/9/01
              $   50.00   $   50.00                  $0.00

FEEPATIENT,MST A                 3/22/01   11200-22      1307      5/9/01
                                                -23
                                                -47
                                                -52
                                                -54
                                                -55
              $   70.00   $   20.51        1         $49.49
```

Example #3

```
Invoice Number: 2300          Vendor Name: ALBANY MED CENTER
  Date Received: 07/06/03        Invoice Date: 7/6/03
  FPPS Claim ID: 4321            Patient Account #: TESTPAN1
         ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
PATIENT                          SVC DATE  CPT-MOD /REV  BATCH NO. VOUCHER DATE
   FPPS LINE  AMT CLAIMED AMT PAID  UNITS  ADJ CODE  ADJ AMT         REMIT RMK
================================================================================

FEEPATIENT,FEE A                 6/16/03   90937   /190  1656
   1          $  200.00   $  113.87  2     4         $86.13          MA125

FEEPATIENT,FEE A                 6/17/03   90937   /190  1656
   2          $  200.00   $  113.87  2     4         $86.13          MA125

FEEPATIENT,FEE A                 6/18/03   90937   /190  1656
   3          $  200.00   $  113.87  2     4         $86.13          MA125
```

CIVIL HOSPITAL ANCILLARY
Output Menu
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

Example

```
Select Outputs Main Menu Option: fpps Claim Inquiry
FPPS CLAIM ID: 414
DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


FPPS Claim Inquiry for ID: 414                   SEP 17, 2003@09:33:02  page 1
--------------------------------------------------------------------------------
Outpatient/Ancillary Invoice: 63995
Enter RETURN to continue or '^' to exit:

FPPS CLAIM ID:
```

COMMUNITY NURSING HOME
Batch Main Menu - CNH
List Items in Batch

New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term “Adjustment Reason” replaces the VistA Fee term “Suspend Code.” Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Introduction

The List Items in Batch option is used to view all payment records in a selected batch. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

Example

```
Patient Name ('*' Reimbursement to Veteran   '+' Cancellation Activity)
             ('#' Voided Payment)                          Batch Number
   Vendor Name                              Vendor ID   Invoice #  Dt Inv Rec'd
   FR DATE    TO DATE  CLAIMED      PAID    ADJ CODE
================================================================================


FEEPATIENT,FEE A                   405-34-5678              1555
   AMESBURY NURSING HOME                          046001067    2060        7/31/01
    FPPS Claim ID: 4300    FPPS Line: 1-5
    07/31/01 07/31/01  1850.00    1800.00       45
    Dx: V65.0
```

COMMUNITY NURSING HOME
Output Menu-CNH
Check Display


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for. For CNH, the user can account for all lines by answering YES
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example

```
                    PAYMENT HISTORY FOR CHECK # 103
                    ------------------------------                    Page: 1
                      FEE PROGRAM:  COMMUNITY NURSING HOME
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   From Date   To Date                                  Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  SEAL POINT MEDICAL CNH          VENDOR ID:  444444005Z

Patient:  CATO,ANNA                    Patient ID:  259-68-6666
   9/1/93      9/5/93                                   966      1502
        40.00       30.00   1         10.00
   FPPS Claim ID: 4567    FPPS Line Item: ALL

    >>>Check # 103  Date Paid:  5/23/94<<<
```

COMMUNITY NURSING HOME
Outputs Menu - CNH
Invoice Display


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Invoice Display option is used to view or print detailed line items associated with a selected Civil Hospital invoice.

NOTE: Although you may view and print both Civil Hospital and Contract Nursing Home invoices with this option, it should be used to view and print Civil Hospital invoices only.

Example #1

```
                                INVOICE DISPLAY
                               =================

Veteran's Name                                      Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

DOUGLAS,BOB  123-23-2323                            TESTPCN1
    GOOD TIME,NURSING HOME INC.                  141509755a       2315
    4321          ALL              07/08/03   7/8/03     06/01/03   06/30/03
    100.00       30.00       29        6         70.00          MA125,N45

    Associated 7078: X95003.0004
    Batch #: 1675                        Date Finalized:
```

Example #2

```
                                INVOICE DISPLAY
                               =================

Veteran's Name                                      Patient Control Number
('*'Reimbursement to Veteran   '+' Cancellation Activity)   '#' Voided Payment)
    Vendor Name                                Vendor ID     Invoice #
    FPPS Claim ID FPPS Line Item   Date Rec.  Inv. Date  Fr Date    To Date
    Amt Claimed  Amt Paid    Cov.Days  Adj Code  Adj Amount     Remit Remark
================================================================================

FEEPATIENT,FEE A  405-34-5678                       TESTPCN
    BETH ISRAEL HOSPITAL                         042103881        2314
    4300          1-5              07/08/03   7/8/03     04/09/03   04/09/03
    100.00       50.00       1         B13       50.00          MA125
    Dx: 724.1
    Associated 7078: C95003.0079
    Batch #: 1678                        Date Finalized:
```

COMMUNITY NURSING HOME:
Output Menu
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction:

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

Example

```
Select Output Main Menu – CNH Option: FPPS Claim Inquiry
FPPS CLAIM ID: 9809

FPPS Claim Inquiry for ID: 9809                      SEP 11,2003
Page 1
-------------------------------------------------------------------------------
Inpatient (CNH) Invoice: 63757
Enter RETURN to continue or ^ to exit:
```

COMMUNITY NURSING HOME
Payment Main Menu - CNH
Edit CNH Payment


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for. For CNH, the user can account for all lines by answering YES.

Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Community Nursing Home claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Community Nursing Home claim.

FBAASUPERVISOR - required to edit payments in batches that have been released by a supervisor; or payments entered by other users.

Introduction

The Edit CNH Payment option is used to edit data for a previously entered Community Nursing Home payment. Payments can only be entered by using the Enter CNH Payment option.

You may edit or delete the entire invoice, or individual data items. You cannot edit payments in batches that have been transmitted. You may not delete the data in required fields.

Example

```
Select FEE BASIS BATCH NUMBER: 159        C15003

Select Invoice Number: 330


                            INVOICE DISPLAY
                           =================

Patient: WARD,STEPHEN                     Patient ID: 708-01-0120
                        FEE PROGRAM: CONTRACT NURSING HOME
   ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
Vendor Name                           Vendor ID   Invoice #
FPPS Claim ID  FPPS Line Item  Date Rec. Inv. Date Fr Date  To Date
Amt Claimed    Amt  Paid   Cov.Days  Adj Code Adj Amount Remit Remark
=========================================================================

Vendor: SUNNY VIEW NURSING HOME     Vendor ID: 908967789  63709
12345             ALL         12/05/94    10/01/94    11/1/94
12.00             11.00         31    42        1.00      MA125
  Associated 7078: C90622.0107
    Batch #: 159                        Date Finalized:



Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): DEC 5,1994// <RET>
VENDOR INVOICE DATE: DEC 1,1994// <RET>
PATIENT CONTROL NUMBER: 1234594// <RET>
Is this an EDI claim from the FPPS System? YES// <RET>
FPPS CLAIM ID: 4321// <RET>
Does this VistA invoice cover all line items on the FPPS Claim? YES// <RET>
VENDOR: SUNNY VIEW NURSING HOME// <RET>
VETERAN: WARD,STEPHEN// <RET>
TREATMENT FROM DATE: OCT 1,1994// <RET>
TREATMENT TO DATE: NOV 1,1994// <RET>
COVERED DAYS? 31// <RET>
```

```
AMOUNT CLAIMED: 12// <RET>
AMOUNT PAID: 12// <RET>
Select ADJUSTMENT REASON: 42// <RET>
ADJUSTMENT GROUP: CO// <RET>
ADJUSTMENT AMOUNT: 1// <RET>
BATCH NUMBER: 159// <RET>
PURPOSE OF VISIT: COMMUNITY NURSING HOME FOR NSC DISABILITY(IES)// <RET>
PATIENT TYPE CODE: MEDICAL// <RET>
PRIMARY SERVICE FACILITY: ALBANY ISC// <RET>
Current List of Remittance Remarks: MA125,
REMITTANCE REMARK: <RET>
```

COMMUNITY NURSING HOME
Payment Main Menu - CNH
Enter CNH Payment

New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for. For CNH, the user can account for all lines by answering YES.

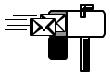
Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Community Nursing Home claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Community Nursing Home claim.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

The Enter CNH Payment option is used to enter Community Nursing Home payments. Only Community Nursing Home payments can be entered through this option. All other Fee Basis payments must be entered through other menus. Only batches opened by you and having a current status of OPEN may be entered.

You cannot enter new vendors with this option. If you wish to enter a new vendor, use the Vendor Enter/Edit option on the Community Nursing Home Main Menu.

The system calculates the amount to be paid based on data in the CNH ACTIVITY file. The system will automatically assign invoice numbers to each payment. There is a separate invoice number for each payment line.

The system will not accept payments for a period that is not within the patient's authorized dates.

Example

```
Select FEE BASIS BATCH NUMBER: 178        C93999

Payments for which Month/Year: 6/93  (JUN 1993)



Select Patient: ABBOTT,JOHN A.

ABBOTT,JOHN A.                          Pt.ID: 411-01-0101P
124 SMITH ROAD                            DOB: JAN 1,1901
SMITH                                     TEL: Not on File
IDAHO 12456                            CLAIM #: 411010101P
                                        COUNTY: ADAMS

Primary Elig. Code: SC  --  PENDING VERIFICATION  AUG 10, 1992
Other Elig. Code(s):

 Service Connected: NO
 Rated Disabilities: NONE STATED
    Health Insurance: YES
    Insurance Co.     Subscriber ID  Group   Holder  Effective Expires
    ========================================================================
    AETNA             252525             201        SPOUSE
12/31/85
```

```
    GHI               12345             123         SELF    01/01/91
    HEALTH INSURANCE                    OPD-45      SELF    01/01/94
Want to add NEW insurance data? No// <RET>
Are there any discrepancies with insurance data on file? No// <RET>

Patient Name: ABBOTT,JOHN A.                              Pt.ID: 411-01-0101P

AUTHORIZATIONS:
   (1) FR: 06/09/93      VENDOR: GOOD TIME NURSING HOME - 987561234
       TO: 06/10/93
                         Authorization Type: CONTRACT NURSING HOME
           Purpose of Visit: COMMUNITY NURSING HOME FOR SC DISABILITY(IES)
           DX:
       County: ADAMS                    PSA: BAY PINES, FL

           REMARKS:
              NURSING HOME


Is this the correct Authorization period (Y/N)? Yes// <RET>

Veteran: ABBOTT,JOHN A.             SSN: 411-01-0101P
     Date/Time           Transaction      Type

June  9, 1993  10:00      Admission     All Other
June 10, 1993  10:00      Discharge     Regular


Amount based on 1 days of care.

    Total Amount calculated is: $   94.00

Want to Continue with Payment Entry? YES// <RET>

Invoice # 293 assigned to this invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): 6/15/93  (JUN 15, 1993)

Enter Vendor Invoice Date: 6/11/93  (JUN 11, 1993)
PATIENT CONTROL NUMBER: 1234594
Is this an EDI claim from the FPPS system? YES
FPPS CLAIM ID: 4321
Does this VistA invoice cover all line items on the FPPS Claim? YES
COVERED DAYS: 31// <RET>
AMOUNT CLAIMED: 100.00
AMOUNT PAID: 94.00
```

```
Select ADJUSTMENT REASON: 42  Charges exceed our fee schedule or maximum
allowable amount.
ADJUSTMENT GROUP: CO Contractual Obligation
ADJUSTMENT AMOUNT: 6.00//<RET>
Current list of Remittance Remarks: none
REMITTANCE REMARK: MA125 Per legislation governing this program, payment
constitutes payment in full.
Current list of Remittance Remarks: MA125,
REMITTANCE REMARK: <RET>


Select Patient:
```

MEDICAL FEE
Batch Main Menu
List Items in Batch

 New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The List Items in Batch option is used to view all payment records in a selected batch. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

Example

```
Patient Name ('*' Reimbursement to Patient   '+' Cancellation Activity)
             ('#' Voided Payment)                          Batch #  Voucher Date
   Vendor Name                              Vendor ID  Invoice #     Date Rec'd.
    SVC DATE  CPT-MOD   SERVICE PROVIDED               FPPS CLAIM  FPPS LINE
    CLAIMED      PAID         ADJ CODE   ADJ AMOUNT
================================================================================


FEEPATIENT,MST B                   604-32-4567           1692     7/12/03
   ALPINE NURSING HOME                     521591700    2322        7/12/03
    11/15/02  77300     RADIATION THERAPY DOSE PLAN   32100       2
    150.00        80.74       4,B13      50.00,19.26

               Invoice #: 2322   Totals: $ 80.74
```

```
FEEPATIENT,MST B                   604-32-4567           1692     7/12/03
   ACUTE CARE SPECIALISTS INC             341339182    2324        7/12/03
    11/20/02  99361     PHYSICIAN/TEAM CONFERENCE     1           4
    100.00        80.00       B13        20.00
    >>>Check # 81212127  Date Paid:  7/17/03<<<

               Invoice #: 2324   Totals: $ 80.00

FEEPATIENT,MST B                   604-32-4567           1692     7/12/03
   ACUTE CARE SPECIALISTS INC             341339182    2325        7/12/03
    11/15/02  40830-26  REPAIR MOUTH LACERATION       50432       1
                  -53
    200.00       129.66       4,B13      20.34,50.00
    >>>Check # CC212127  Date Paid:  7/14/03<<<

               Invoice #: 2325   Totals: $ 129.66
```

MEDICAL FEE
Output Menu
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction:

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

EXAMPLE

```
Select Outputs Main Menu Option: fpps Claim Inquiry
FPPS CLAIM ID: 414
DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


FPPS Claim Inquiry for ID: 414                  SEP 17, 2003@09:33:02  page 1
--------------------------------------------------------------------------------
Outpatient/Ancillary Invoice: 63995
Enter RETURN to continue or '^' to exit:

FPPS CLAIM ID:
```

MEDICAL FEE
Output Menu
Check Display


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for. For CNH, the user can account for all lines by answering YES
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example

```
Select Outputs Main Menu Option: check Display

Select Check Number: 63995000

DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


                    PAYMENT HISTORY FOR CHECK # 63995000
                    -----------------------------------              Page: 1

                      FEE PROGRAM:  OUTPATIENT
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   Svc Date  CPT-MOD   Rev.Code                            Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  CHANDRASHEKAR MD,M               VENDOR ID:  330286613

Patient:  LAWRENCE,WELK                 Patient ID:  070-54-0002
   6/2/03    42400-AH  088                                 22068    63995
      654.00      113.00   35,42       447.98, 93.02
           FPPS Claim ID: 414          FPPS Line Item: 1
    >>>Check # 63995000  Date Paid:  9/9/03<<<
   6/2/03    25111     033                                 22068    63995
       786.00      385.73   42        400.27
           FPPS Claim ID: 414
```

MEDICAL FEE
Output Menu
Invoice Display


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.
FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for. For CNH, the user can account for all lines by answering YES
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.
Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Invoice Display option is used to view or print detailed line items associated with a selected Outpatient Medical invoice.

Example

```
Select Outputs Main Menu Option: invoice Display


Select Invoice Number:  63995

Invoice Number: 63995         Vendor Name: CHANDRASHEKAR MD,M
  Date Received: 06/12/03        Invoice Date: 6/12/03
  FPPS Claim ID: 414             Patient Account #: lawjan9
         ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
PATIENT                          SVC DATE  CPT-MOD /REV  BATCH NO. VOUCHER DATE
   FPPS LINE  AMT CLAIMED AMT PAID  UNITS  ADJ CODE  ADJ AMT         REMIT RMK
================================================================================

LAWRENCE,WELK                    6/2/03    42400-AH/088  22068     9/10/03
   1          $654.00     $  113.00  1     35,42       $447.98, 93.02 MA125,N1
    >>>Check # 63995000  Date Paid:  9/9/03<<<

LAWRENCE,WELK                    6/2/03    25111   /033  22068     9/10/03
   2          $  786.00   $  385.73  1     42        $400.27         N14,N1
    >>>Check # 63995000  Date Paid:  9/9/03<<<

Select Invoice Number:
```

MEDICAL FEE
Outputs Menu
Payment History Display


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Payment History Display option is used to view all medical payment data for a selected patient. Payments are listed in inverse date order by service date.

Example

```
Select Outputs Main Menu Option: payment History Display


Select Fee Patient: lawrence
   1   LAWRENCE , WELK         7-17-25    561282421    YES    40%    SC VETERAN
WL/LL/
   2   LAWRENCE,ARTHUR        1-16-32    525706906    YES    100%    SC VETERAN
   LL/        **ADVANCE DIRECTIVE - YES 5/22/01**
        VA TRANSPORT PLEASE EXPEDITE [m
   3   LAWRENCE,BARNEY J        6-18-34    445348949    NO      NSC VETERAN
   MT COPAY EXEMPT      **ADVANCE DIRECTIVE - NO 5/30/98**
   4   LAWRENCE,BILLY J        9-2-38    422460071    NO      NSC VETERAN    LL/
       MT: REQUIRED [m
   5   LAWRENCE,CHARLES J        1-3-25    438181317    NO      NSC VETERAN    W
L/LL/
ENTER '^' TO STOP, OR
CHOOSE 1-5: X  LAWRENCE, WELK        7-17-25    561282421    YES    40%
SC VETERAN    WL/LL/


LAWRENCE , WELK                      Pt.ID: 561-28-2421
6120 ARDEN AVE                           DOB: JUL 17,1925
SAN BERNARDINO                           TEL: 714-862-5070
CALIFORNIA 92404                     CLAIM #: 07030533
                                      COUNTY: SAN BERNARDINO

Primary Elig. Code: SC LESS THAN 50%  --  VERIFIED  MAR 05, 1990
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 40%
 Rated Disabilities: TRAUMATIC BRAIN DISEASE (30%-SC)
                     FACIAL SCARS (10%-SC)

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information


Enter RETURN to continue or '^' to exit:


Fee ID Card #: 1111116                 Fee Card Issue Date: 2/21/2003

Patient Name: LAWRENCE, WELK                              Pt.ID: 561-28-2421

AUTHORIZATIONS:
   (1) FR: 2/21/2003     VENDOR: PHARMERICA - 521198121
       TO: 2/20/2006
                         Authorization Type: Outpatient - ID Card
          Purpose of Visit: MISC. (ELIG. UNDER VOC. REHAB, OTHER FED. AGENCY OR
 ALLIED BENE.)
          DX: no way
       County: SAN BERNARDINO           PSA: CENTRAL CALIFORNIA HCS

Enter RETURN to continue or '^' to exit:
```

Example (cont.)

```
Patient: LAWRENCE,WELK                  SSN: 561-28-2421
          ('*' Reimb. to Patient  '+' Cancel. Activity  '#' Voided Payment)
    (paid symbol: 'R' RBRVS  'F' 75th percentile  'C' contract  'M' Mill Bill
                  'U' U&C)
  Svc Date  CPT-MOD   Rev.Code Units  Patient Account No.   Invoice #  Batch #
     Amt Claimed  Amt Paid      Adj Code  Adj Amount      Remit Remark VoucherDt

================================================================================


Vendor: NANCY A JONES D O     Vendor ID: 330663259                Obl.#: C27042

  7/2/03    25111-AH  003      1      lawmil2299              63994    22069
      77.00        77.00U                0.00            N14,N1       09/10/03
     FPPS Claim ID: 4441        FPPS Line Item: 1
    >>>Check # 63994000  Date Paid:  9/9/03<<<

Vendor: NANCY A JONES D O     Vendor ID: 330663259                Obl.#: C27042

  7/2/03    10121     044      1      lawmil2299              63994    22069
     600.00       211.00U       35,42     303.21,85.79    MA125,N1     09/10/03
     FPPS Claim ID: 4441        FPPS Line Item: 2
    >>>Check # 63994000  Date Paid:  9/9/03<<<
Enter RETURN to continue or '^' to exit:

Select Fee Patient:
```

MEDICAL FEE
Payment Process Menu
Edit Payment


New Prompts:

Patient Account Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character numeric ID created by FPPS system. Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim ID number for each invoice.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, both the Revenue Code and the CPT/HCPCS code must be entered during Phase One of the Fee Basis Replacement project.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

FPPS Line Item: Only asked if the user answered YES to the *Is this an EDI Claim from the FPPS system?* prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two (2) Adjustment Reasons can be used for each Medical Fee outpatient claim.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended."

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two (2) Remittance Remarks can be used for each Medical Fee outpatient claim.

FBAASUPERVISOR - allows you to edit payments from batches that have been released by a supervisor.

Introduction

The Edit Payment option is used to edit data for a previously entered Medical Fee payment. You may also delete an entire existing payment entry or delete individual data items, other than required fields. You cannot edit payments in batches that have been finalized.

Example

```
Select Payment menu Option: EDit Payment

Select FEE BASIS PAYMENT PATIENT:    FEEPATIENT,FEE A

Select VENDOR:    ACUTE CARE SPECIALISTS INC
Date of Service: 3/10/2003   MAR 10, 2003..
Select SERVICE PROVIDED: 98940       CHIROPRACTIC MANIPULATION
Service Provided: 98940//   <RET>     CHIROPRACTIC MANIPULATION
Current list of modifiers: none
Select CPT MODIFIER: <RET>

REVENUE CODE: <RET>
UNITS PAID: 1// <RET>
SITE OF SERVICE ZIP CODE: 44313// <RET>
Is this line item for a contracted service? No//   NO
PLACE OF SERVICE: OFFICE (11)// <RET>
AMOUNT CLAIMED: 25// <RET>
  Fee schedule amount is $23.55 from the 2003 RBRVS FEE SCHEDULE

AMOUNT PAID: 23.55// <RET>
Up to 2 adjustment reasons can be specified.
Select ADJUSTMENT REASON: 119// <RET>
  ADJUSTMENT GROUP: CO// <RET>
  ADJUSTMENT AMOUNT: 1.00// <RET>

Select ADJUSTMENT REASON: 42// <RET>
  ADJUSTMENT GROUP: CO// <RET>
  ADJUSTMENT AMOUNT: 0.45// <RET>

Is this an EDI Claim from the FPPS System? YES// <RET>

FPPS Claim ID: 1234// <RET>
FPPS LINE ITEM: 1// <RET>
Exit ('^') allowed now

PRIMARY SERVICE FACILITY: ALBANY// <RET>
OBLIGATION NUMBER: C95003// <RET>
DATE CORRECT INVOICE RECEIVED: APR 27,2003// <RET>
VENDOR INVOICE DATE: APR 25,2003// <RET>
PATIENT ACCOUNT NUMBER: 4753822// <RET>

PATIENT TYPE CODE: MEDICAL// <RET>
TREATMENT TYPE CODE: SHORT TERM FEE STATUS// <RET>
```

Example, cont.

```
PURPOSE OF VISIT: CHIROPRACTIC CARE// <RET>
PRIMARY DIAGNOSIS: 724.1// <RET>
HCFA TYPE OF SERVICE:
SERVICE CONNECTED CONDITION?: YES// <RET>

REMITTANCE REMARK: MA125// <RET>
REMITTANCE REMARK: <RET>

Select SERVICE PROVIDED: <RET>

Select FEE BASIS PAYMENT PATIENT:
```

MEDICAL FEE
Payment Process Menu
Enter Payment

New Prompts:

Patient Account Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character numeric ID created by FPPS system. Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim ID number for each invoice.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, both the Revenue Code and the CPT/HCPCS code must be entered during Phase One of the Fee Basis Replacement project.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

FPPS Line Item: Only asked if the user answered YES to the *Is this an EDI Claim from the FPPS system?* prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two (2) Adjustment Reasons can be used for each Medical Fee outpatient claim.

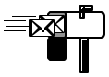
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended."

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two (2) Remittance Remarks can be used for each Medical Fee outpatient claim.

 FBAA ESTABLISH VENDOR - required to enter new or edit existing vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

The Enter Payment option is used to enter new Medical Fee payments. Only authorized Medical Fee invoices/payments may be entered through this option. All other Fee Basis payments are entered through other payment options. The Edit Payment option must be used to make changes or adjustments to existing payments.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

Every prompt should be answered. Failure to enter a response or entering a <RET> or an up-arrow <^> at any prompt may result in an incomplete entry or deletion of the entire entry.

Example

```
Select Payment Menu Option: ENTER Payment

Select FEE BASIS BATCH NUMBER: 1591

Obligation #: C95003


Select Patient:    FEEPATIENT,FEE A


FEEPATIENT,FEE A                        Pt.ID: 405-34-5678
1313 MOCKINGBIRD LN                       DOB: MAR 15,1940
HAMPTON                                   TEL: 555-5555
VIRGINIA 23664                         CLAIM #: Not on File
                                        COUNTY: HAMPTON (IC)
```

Example, cont.

```
Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  SEP 05, 2000
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 60%
 Rated Disabilities: NONE STATED

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information
                 ***  Patient has Insurance Buffer entries  ***

Want to add NEW insurance data? No//   NO

Are there any discrepancies with insurance data on file? No//   NO


Patient Name: FEEPATIENT,FEE A                          Pt.ID: 405-34-5678

AUTHORIZATIONS:
   (1) FR: 3/1/2003      VENDOR: Not Specified

       TO: 9/30/2003
                         Authorization Type: Unknown
           DX: test
               test2
               test3
       County: HAMPTON (IC)             PSA: Unknown

           REMARKS:
              TEST

   (2) FR: 2/9/2003      VENDOR: Not Specified
       TO: 5/20/2003
                         Authorization Type: Outpatient - Short Term
           Purpose of Visit: CHIROPRACTIC CARE
           DX:
       County: HAMPTON (IC)             PSA: ALBANY

Enter a number (1-28): 2

AUTHORIZATION REMARKS: <RET>
  1>No remarks
EDIT Option: <RET>
DX LINE 1: <RET>
DX LINE 2: <RET>
DX LINE 3: <RET>


Select FEE BASIS VENDOR NAME: ACUTE   CARE SPECIALISTS INC    341339182  DOCTOR
OF MEDIC
          2620 RIDGEWOOD RD  100
          TEST
          AKRON, OH  44313    TEL. #:  1-800-837-0703
```

Example, cont.

```
Patient Name: FEEPATIENT,FEE A                  Pt.ID: 405-34-5678

                      ***  VENDOR DEMOGRAPHICS  ***

       Name:  ACUTE CARE SPECIALISTS INC       ID Number: 341339182
    Address:  2620 RIDGEWOOD RD  100           Specialty: PHYSICIANS-NONDIPLOM
 Address [2]:  TEST
       City:  AKRON                                Type: PHYSICIAN
      State:  OHIO                    Participation Code: DOCTOR OF MEDICINE
        ZIP:  44313                   Medicare ID Number: 333333
     County:  ADAMS                                Chain:
      Phone:  1-800-837-0703
        Fax:
 Type (FPDS):  SMALL BUSINESS
 Austin Name:  ACUTE CARE SPECIALISTS INC
 Last Change                                Last Change by Station 500
   TO Austin:  5/18/99                        FROM Austin:  5/18/99

Want to Edit data? NO// <RET>

Patient Name: FEEPATIENT,FEE A             SSN: 405345678

  VENDOR: ACUTE CARE SPECIALISTS INC
    2620 RIDGEWOOD RD  100
    AKRON, OHIO   44313
         ('*' Reimb. to Patient  '+' Cancel. Activity   '#' Voided Payment)
 SVC DATE  CPT-MODIFIER       AMT CLAIMED AMT PAID  CODE   INVOICE # BATCH #
--------------------------------------------------------------------------------

  03/07/03  90819             $   10.00   $    9.00 1      2200      1600
  03/04/03  17304             $  100.00   $   90.00 1      2178      1629
  03/04/03  10180             $   50.00   $   50.00        2178      1629
  03/03/03  11200-50          $     .09   $     .09        2191      49
                -51
                -52
* 02/19/03  99284             $  150.00   $   86.62 1      2172      1629
  11/07/02  99284             $ 1000.00   $     .00 4      2168      1600
  08/27/02  99025             $   50.00   $   50.00        2162      1600
  08/26/02  G0153             $   20.00   $   20.00        2153      1591
  08/12/02  10060-23          $    2.22   $    2.22        2171      1400
  08/12/02  10060-23          $     .25   $     .00 4      2175      1400
  12/05/01  90801             $   20.00   $   20.00        2050      1549
  12/05/01  33315-26          $   40.00   $   40.00        2050      1549

Want a new Invoice number assigned? YES// <RET>

Invoice # 2214 assigned to this Invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): T-2  (APR 27, 2003)

Enter Vendor Invoice Date: T-4  (APR 25, 2003)

Patient Account Number: 4753822
```

Example, cont.

```
Is this an EDI Claim from the FPPS System? YES
FPPS Claim ID: 345111178

Will any line items in this invoice be for contracted services? No// YES

Date of Service: 3/10/2003   MAR 10, 2003..

$ 3 for travel already entered for this date of service

Total already paid on ID Card for month:   $ 0   Maximum allowed: $ 125
Total already paid on All/Other for month: $ 140

SITE OF SERVICE ZIP CODE: 44313// <RET>

Select Service Provided: 98940       CHIROPRACTIC MANIPULATION
Current list of modifiers: none

Select CPT MODIFIER: <RET>

Major Category: MEDICINE
  Sub-Category: CHIROPRACTIC MANIPULATIVE TREATMENT
      Procedure: 98940   CHIROPRACTIC MANIPULATION

                   Detail Description
                   ==================
CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

CODE TEXT MAY BE INACCURATE
Is this correct? YES// <RET>
       CHIROPRACTIC MANIPULATION

REVENUE CODE: <RET>

UNITS PAID: 1// <RET>

FPPS Line Item: 1
Is this line item for a contracted service? No//   <RET>
Select PLACE OF SERVICE: 11       OFFICE

AMOUNT CLAIMED: 25
  Fee schedule amount is $23.55 from the 2003 RBRVS FEE SCHEDULE

AMOUNT PAID: 23.55// <RET>
Up to 2 adjustment reasons can be specified.

Select ADJUSTMENT REASON: 119  Benefit maximum for this time period has been reached.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 1.45// 1.00

Select ADJUSTMENT REASON: 42  Charges exceed our fee schedule or maximum allowable
amount.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 0.45// <RET>
```

Example, cont.

```
PRIMARY DIAGNOSIS: 724.1  724.1     PAIN IN THORACIC SPINE
         ...OK? Yes// <RET>  (Yes)

HCFA TYPE OF SERVICE: <RET>
SERVICE CONNECTED CONDITION?: Y  (YES)
REMITTANCE REMARK: MA125  Per legislation governing this program, payment constitutes
payment in full.
REMITTANCE REMARK: <RET>

Select Service Provided: <RET>

Date of Service: <RET>

Invoice: 2214 Totals $ 23.55
```

MEDICAL FEE
Payment Menu
Patient Re-imbursement for Ancillary Services


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

. *Adjustment Reason:* Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.

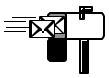
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

 FBAA ESTABLISH VENDOR - required to enter new vendors.

 FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

The Patient Reimbursement for Ancillary Services option is used to reimburse a patient for ancillary services paid for by the patient. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

The optional CPT MODIFIER prompt allows you to break down services provided to the modifier level.

After the amount claimed is entered, two fee schedules for outpatient services are checked by the software. The system first checks the RBRVS (Resource Based Relative Value Scale) physician fee schedule. If the service is not covered by the RBRVS fee schedule, the system then checks the site-specific VA fee schedule. (This fee schedule is based on payments made during the previous fiscal year by the site and is computed as the 75th percentile of the amount claimed if there where eight or more payments made for that service.) If a fee schedule amount cannot be obtained from either of these fee schedules, you will see the message "Unable to determine a FEE schedule amount."

Displays, which include line item information, include check information, date paid, and/or check cancellation information. Line items that had previously been cancelled are annotated with a plus sign (+).

Example

```
Select Payment Process Menu Option: PATient Reimbursement for Ancillary Services


Select FEE BASIS BATCH NUMBER: 22096
  Obligation #: C27042




Select Patient: gabart, melita  GABART,MELITA      1-10-25    575285105    YES    10%
   SC VETERAN    LL/SD/        **ADVANCE DIRECTIVE - NO 7/22/03**
 Enrollment Priority: GROUP 3    Category: IN PROCESS    End Date:



GABART,MELITA                          Pt.ID: 575-28-5105
10001 JJJJJJO DR                         DOB: JAN 10,1925
VICTORVILLE                              TEL: 760 245-1689
CALIFORNIA 92929                      CLAIM #: 16076516
                                       COUNTY: SAN BERNARDINO

Primary Elig. Code: SC LESS THAN 50%  --  VERIFIED  OCT 31, 1989
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 10%
 Rated Disabilities: DEGENERATIVE ARTHRITIS (10%-SC)
                     SCARS (0%-SC)
                     DUODENAL ULCER (0%-SC)
                     VARICOSE VEINS (0%-SC)

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information

Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO



Patient Name: GABART,MELITA                                Pt.ID: 575-28-5105

AUTHORIZATIONS:
   (1) FR: 8/5/2003      VENDOR: CHARTER OAK BHS - 95462347001
       TO: 8/7/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: HOSPICE CARE (INPT.) FEE BASIS AUTHORITY (CFR 17.50
b)
           DX: psychosis
       County: SAN BERNARDINO           PSA: ATWATER

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
```

```
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.


Enter RETURN to continue or '^' to exit:


Patient Name: GABART,MELITA                              Pt.ID: 575-28-5105
   (2) FR: 6/27/2003     VENDOR: LOMA LINDA UNIV MED CENTER - 95352267901
       TO: 7/7/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: EMERG. NON-VA CARE (INPT/OPT) FOR VET. REC. INPT. C
ARE IN VAMC
           DX: stroke
               hysteria
       County: SAN BERNARDINO           PSA: LOMA LINDA

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.


   (3) FR: 3/1/2003      VENDOR: CHARTER OAK BHS - 95462347001
       TO: 9/5/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: UNAUTHORIZED NON-VA HOSPITAL CARE, SC OR NSC COND
           DX: pschosis
       County: SAN BERNARDINO           PSA: FRESNO

Enter RETURN to continue or '^' to exit:


Patient Name: GABART,MELITA                              Pt.ID: 575-28-5105

           REMARKS:
              HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED
              UNTIL THE PATIENT'S CONDITION IS STABILIZED OR IMPROVED
              ENOUGH FOR TRANSFER, WITHOUT HAZARD, TO THIS OR ANOTHER
              VA FACILITY FOR CONTINUED CARE.  PAYMENT FOR HOSPITAL
              SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
              ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL
              CONSTITUTE PAYMENT IN FULL.




Enter a number (1-3): 3

Patient:  GABART,MELITA

Patient's Permanent address:
  Address Line 1: 10001 JJJJJJO DR
  City:           VICTORVILLE
  State:          CALIFORNIA
  Zip:            92929
  County          SAN BERNARDINO
```

```
Want to edit Permanent Address data? No//   NO

Want to add Confidential Address data? No//   NO
AUTHORIZATION REMARKS:
HOSPITAL AND PROFESSIONAL CARE WILL ONLY BE AUTHORIZED UNTIL THE
PATIENT'S CONDITION IS STABILIZED OR IMPROVED ENOUGH FOR TRANSFER,
WITHOUT HAZARD, TO THIS OR ANOTHER VA FACILITY FOR CONTINUED CARE.
PAYMENT FOR HOSPITAL SERVICES WILL BE LIMITED TO AMOUNTS BASED ON RATES
ESTABLISHED BY MEDICARE APPROPRIATE DRG'S AND WILL CONSTITUTE PAYMENT IN
FULL.

  Edit? NO// <RET>
DX LINE 1: pschosis// <RET>
DX LINE 2:
DX LINE 3:


Select FEE BASIS VENDOR NAME: nancy a jones
     1   NANCY A JONES D O              330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112

     2   NANCY A JONES DO               330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112

CHOOSE 1-2: 1  NANCY A JONES D O        330663259  DOCTOR OF MEDIC
          16003 TUSCOLA ROAD
          SUITE H
          APPLE VALLEY, CA  92307    TEL. #:  619 946-2112



Patient Name: GABA,MELY                          Pt.ID: 575-28-5105

                      ***  VENDOR DEMOGRAPHICS  ***

        Name:  NANCY A JONES D O                ID Number: 330663259
     Address:  16003 TUSCOLA ROAD               Specialty: PHYSICIANS-NONDIPLOM
 Address [2]:  SUITE H
        City:  APPLE VALLEY                         Type: PHYSICIAN
       State:  CALIFORNIA             Participation Code: DOCTOR OF MEDICINE
         ZIP:  92307                  Medicare ID Number:
      County:  SAN BERNARDINO                    Chain:
       Phone:  619 946-2112
         Fax:
 Type (FPDS):
 Austin Name:  N A JONES DO
 Last Change                                Last Change by Station 605
   TO Austin:  3/25/96                        FROM Austin:  4/1/96
Want to Edit data? NO// <RET>


Vendor has no prior payments for this patient

Want a new Invoice number assigned? YES// y  YES

Invoice # 64041 assigned to this Invoice
```

```
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): t-20  (AUG 26, 2003)

Enter Vendor Invoice Date: t-20  (AUG 26, 2003)
PATIENT ACCOUNT NUMBER: 123gaba987
Is this an EDI Claim from the FPPS system? y  YES
FPPS CLAIM ID: 43215


Date of Service: t-31   AUG 15, 2003

SITE OF SERVICE ZIP CODE: 92307// <RET>

Select Service Provided: 10121       REMOVE FOREIGN BODY

Current list of modifiers: none
Select CPT MODIFIER: <RET>

Major Category: SURGERY
  Sub-Category: INTEGUMENTARY SYSTEM
      Procedure: 10121   REMOVE FOREIGN BODY

                   Detail Description
                   ==================
INCISION AND REMOVAL OF FOREIGN BODY, SUBCUTANEOUS TISSUES; COMPLICATED
Is this correct? YES// <RET>
       REMOVE FOREIGN BODY
REVENUE CODE: 222       TECH SUPPORT CHG     TECHNICAL SUPPPORT CHARGE
UNITS PAID: 1// <RET>
FPPS LINE ITEM: 2
Select PLACE OF SERVICE: 11       OFFICE
AMOUNT CLAIMED: 654
  Fee schedule amount is $216.74 from the 2002 RBRVS FEE SCHEDULE

AMOUNT PAID: 216.74//215

Current list of Adjustments: none
Select ADJUSTMENT REASON: 35    Benefit maximum has been reached.
ADJUSTMENT GROUP: co    Contractual Obligations
ADJUSTMENT AMOUNT: 439.00// 400

Current list of Adjustments:  Code: 35      Group: CO   Amount: $400.00

Select ADJUSTMENT REASON: 42    Charges exceed our fee schedule or maximum
              allowable amount.
ADJUSTMENT GROUP: oa    Other adjustments
ADJUSTMENT AMOUNT: 39.00// 39.00
HCFA TYPE OF SERVICE:
SERVICE CONNECTED CONDITION?: y  (YES)

Current list of Remittance Remarks: none

Select REMITTANCE REMARK: N1
     1   N1    You may appeal this decision in writing within
               the required time limits following receipt of
               this notice.
     2   N102    This claim has been denied without reviewing the
               medical record because the requested records were
               not received or were not received timely
     3   N11    Denial reversed because of medical review.
```

```
     4   N14    Payment based on a contractual amount or
                agreement, fee schedule, or maximum allowable
                amount.
     5   N18    Payment based on the Medicare allowed amount.
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  N1  You may appeal this decision in writing within
                the required time limits following receipt of
                this notice.

Current list of Remittance Remarks: N1,

Select REMITTANCE REMARK: ma125  Per legislation governing this program, payment
                constitutes payment in full.

Current list of Remittance Remarks: N1, MA125,

Select REMITTANCE REMARK: <RET>

Select Service Provided: <RET>


Date of Service: <RET>

Invoice: 64041 Totals $ 350.00
```

MEDICAL FEE
Payment Process Menu
C&P/Multiple Patient Payment Entry

 New Prompts:

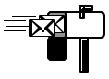
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code wa s not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, both the Revenue Code and the CPT/HCPCS code must be entered during Phase One of the Fee Basis Replacement project.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two (2) Remittance Remarks can be used for each Medical Fee outpatient claim.

 FBAA ESTABLISH VENDOR - required to enter new or edit existing vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

This option is used to enter Compensation and Pension (C&P) and multiple patient payments. The selected patient must be registered and have an open Fee Basis authorization. You may enter additional payments from a previous invoice or payments from a new invoice. A new invoice number is assigned automatically, when required.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

Depending on site parameters at your facility, patient authorization information and vendor demographics may be displayed. Vendor demographics may be edited if you hold the FBAA ESTABLISH VENDOR security key. If there are previous payments to the vendor for the selected patient, a payment history is shown.

Example

Select Payment menu Option: C&P/Multiple Patient Payment Entry

```
Select FEE BASIS BATCH NUMBER:    1591
  Obligation #: C95003


Select FEE BASIS VENDOR NAME:    RADIOLOGY ASO BENN INC.  030226493  ALL OTHER P
ARTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599


                             ***  VENDOR DEMOGRAPHICS  ***
       Name:  RADIOLOGY ASO BENN INC.          ID Number: 030226493
    Address:  PO BOX 1451                      Specialty:
       City:  BENNINGTON                            Type: RADIOLOGY
      State:  VERMONT                Participation Code: ALL OTHER PARTICIPANT
        ZIP:  05201                  Medicare ID Number:
     County:  BENNINGTON                         Chain:
      Phone:  1-800-258-3599
        Fax:
Type (FPDS):
Austin Name:  RADIOLOGY ASO BENN INC
Last Change                                 Last Change
  TO Austin:                                  FROM Austin:  11/18/93


Want to Edit data? NO// <RET>

Want a new Invoice number assigned? YES// <RET>

Invoice # 2232 assigned to this Invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): t-4  (MAY 02, 2003)

Enter Vendor Invoice Date: t-5  (MAY 01, 2003)

The answer to the following will apply to all payments entered via this option.
Are payments for contracted services? No// <RET>
Date of Service: t-40  (MAR 27, 2003)
Select Service Provided:    98940     CHIROPRACTIC MANIPULATION

Current list of modifiers: none
Select CPT MODIFIER: <RET>

Major Category: MEDICINE
  Sub-Category: CHIROPRACTIC MANIPULATIVE TREATMENT
      Procedure: 98940   CHIROPRACTIC MANIPULATION
```

```
                    Detail Description
                   ==================

CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

CODE TEXT MAY BE INACCURATE
Is this correct? YES// <RET>
REVENUE CODE: <RET>
UNITS PAID: 1// <RET>
SITE OF SERVICE ZIP CODE: 05201// 05201

Select PLACE OF SERVICE:    11     OFFICE



Select TYPE OF SERVICE: <RET>
  Fee schedule amount is $23.52 from the 2003 RBRVS FEE SCHEDULE
Enter Amount Paid:  $: 23.52// 23.52

Select REMITTANCE REMARK: MA125  Per legislation governing this program, payment
constitutes payment in full.

Select REMITTANCE REMARK:<RET>

Select Patient: feep
   1   FEEPATIENT,FEE A        3-15-40    405345678           SC VETERAN

   2   FEEPATIENT,FEE B        7-15-40    000003424           NSC VETERAN


  3   FEEPATIENT,MST A        1-20-55    803945832         05-01-01     NSC VET

   4   FEEPATIENT,MST B        5-4-30    604324567           SC VETERAN

CHOOSE 1-4: 1  FEEPATIENT,FEE A        3-15-40    405345678           SC VETERAN


FEEPATIENT,FEE A                        Pt.ID: 405-34-5678
1313 MOCKINGBIRD LN                       DOB: MAR 15,1940
HAMPTON                                   TEL: 555-5555
VIRGINIA 23664                        CLAIM #: Not on File
                                       COUNTY: HAMPTON (IC)

Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  SEP 05, 2000
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

         SC Percent: 60%
 Rated Disabilities: NONE STATED

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
 ==========================================================================
    No Insurance Information

                ***  Patient has Insurance Buffer entries  ***
Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO

Patient Name: FEEPATIENT,FEE A                          Pt.ID: 405-34-5678
```

```
AUTHORIZATIONS:
   (1) FR: 4/9/2003      VENDOR: BETH ISRAEL HOSPITAL - 042103881
       TO: 4/9/2003
                         Authorization Type: CIVIL HOSPITAL
           Purpose of Visit: AUTHORIZED NON-VA HOSPITAL CARE FOR SC COND.
           DX: ADMIT DIAF
       County: HAMPTON (IC)             PSA: ALBANY

           REMARKS:
              Hopitalization and Professional care necessary until
              the patients' condition is stabilized or improved
              enough to permit transfer without hazard to a VA or
              other Federal facility for continued treatment.

   (2) FR: 3/1/2003      VENDOR: Not Specified

TO: 9/30/2003
                         Authorization Type: Unknown

         DX: test
               test2
               test3
       County: HAMPTON (IC)             PSA: Unknown


Enter a number (1-29): 2
PRIMARY DIAGNOSIS:      724.1     PAIN IN THORACIC SPINE
         ...OK? Yes//   <RET>


Vendor has no prior payments for this patient

Payment Data Entered for Patient
Invoice: 2232 Totals: $ 23.52

Select Patient: feep
   1   FEEPATIENT,FEE A        3-15-40    405345678           SC VETERAN

   2   FEEPATIENT,FEE B        7-15-40    000003424           NSC VETERAN

   3   FEEPATIENT,MST A        1-20-55    803945832         05-01-01     NSC VET

   4   FEEPATIENT,MST B        5-4-30    604324567           SC VETERAN

CHOOSE 1-4: 3  FEEPATIENT,MST A        1-20-55    803945832         05-01-01


*** Patient Died on MAY 1,2001
FEEPATIENT,MST A                        Pt.ID: 803-94-5832
12 BUCKROE AVE                            DOB: JAN 20,1955
HAMPTON                                   TEL: 111-111-1111
VIRGINIA 23664                         CLAIM #: Not on File
                                        COUNTY: HAMPTON (IC)

Primary Elig. Code: NSC  --  VERIFIED  MAY 08, 2001
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

  Service Connected: NO
 Rated Disabilities: NONE STATED

    Health Insurance: NO
```

```
Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information

Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO


Invoice: 2232 Totals: $ 47.04

Select Patient: <RET>
Select FEE BASIS BATCH NUMBER: <RET>
```

MEDICAL FEE
Payment Process Menu
Multiple Payment Entry


New Prompts:

Patient Account Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.

Is this an EDI Claim from the FPPS system? - Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character numeric ID created by FPPS system. Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim ID number for each invoice.

Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, both the Revenue Code and the CPT/HCPCS code must be entered during Phase One of the Fee Basis Replacement project.

Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**

FPPS Line Item: Only asked if the user answered YES to the *Is this an EDI Claim from the FPPS system?* prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two (2) Adjustment Reasons can be used for each Medical Fee outpatient claim.

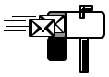
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended."

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two (2) Remittance Remarks can be used for each Medical Fee outpatient claim.

 FBAA ESTABLISH VENDOR - required to enter new or edit existing vendors.

FBAASUPERVISOR - required to enter payments for other users. Enter the clerk's name at the first prompt, "Select FEE BASIS BATCH NUMBER", to see a list of all open batches for that clerk.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

 New insurance information may be uploaded into IB files through this option.

Introduction

The Multiple Payment Entry option is used to enter identical medical payments (except for service date) for a patient. The option was designed to accommodate such services as home nursing where the patient may be seen daily by a visiting nurse. Your name may be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches. You may enter additional payments from a previous invoice (for the same patient) or payments from a new invoice. A new invoice number is assigned automatically, when required.

When using the Multiple Payment option, users should be aware of the Fee Schedule that is used to calculate payments. The Fee Schedule used for the Multiple Payment Option is the current fiscal year minus one. Therefore, a payment made at the beginning of a fiscal year, for a date of service that occurred at the end of the prior fiscal year, will use the Fee Schedule of the current fiscal year minus one, and NOT the fiscal year of the date of service minus one. This is due to the fact that the payment amounts are asked up front, before the date of service is known.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

Depending on site parameters at your facility, patient authorization information and vendor demographics may be displayed. Vendor demographics may be edited if you hold the FBAA ESTABLISH VENDOR security key. If there are previous payments to the vendor for the selected patient, a payment history is shown.

You receive a warning when the patient has reached the maximum payment amount allowed for the month of service; or when you have reached 20 lines from

the maximum number of payment lines allowed in a batch (set by the Max. # Payment Line Items site parameter).

Example

```
   Select Payment menu Option: MULtiple Payment Entry

Select FEE BASIS BATCH NUMBER:    1591
  Obligation #: C95003


Select Patient:    FEEPATIENT,MST A


*** Patient Died on MAY 1,2001
FEEPATIENT,MST A                        Pt.ID: 803-94-5832
12 BUCKROE AVE                            DOB: JAN 20,1955
HAMPTON                                   TEL: 111-111-1111
VIRGINIA 23664                         CLAIM #: Not on File
                                        COUNTY: HAMPTON (IC)

Primary Elig. Code: NSC  --  VERIFIED  MAY 08, 2001
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

  Service Connected: NO
 Rated Disabilities: NONE STATED

    Health Insurance: NO
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ================================================================================
    No Insurance Information

Want to add NEW insurance data? No//   NO
Are there any discrepancies with insurance data on file? No//   NO


Patient Name: FEEPATIENT,MST A                          Pt.ID: 803-94-5832

AUTHORIZATIONS:
   (1) FR: 1/1/2003      VENDOR: Not Specified
       TO: 10/1/2003
                         Authorization Type: Outpatient - Short Term
           Purpose of Visit: HOME HEALTH NURSING SERVICES
           DX:
       County: HAMPTON (IC)             PSA: ALBANY

   (2) FR: 5/1/2001      VENDOR: ACUTE CARE SPECIALISTS INC - 341339182
       TO: 7/31/2001
                         Authorization Type: Outpatient - Short Term
           Purpose of Visit: MILITARY SEXUAL TRAUMA SERVICES
           DX: DX LINE 1
               DX LINE 2
               DX LINE 3
       County: HAMPTON (IC)             PSA: MNTVBB.ISC-ALBANY.VA.GOV
```

```
Enter a number (1-3): 1
AUTHORIZATION REMARKS:
  1>
DX LINE 1: <RET>
DX LINE 2: <RET>
DX LINE 3: <RET>


Select FEE BASIS VENDOR NAME: RADIOLOGY ASO BENN INC.    030226493  ALL OTHER PA
RTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599


Patient Name: FEEPATIENT,MST A                  Pt.ID: 803-94-5832

                      ***  VENDOR DEMOGRAPHICS  ***

        Name:  RADIOLOGY ASO BENN INC.          ID Number: 030226493
     Address:  PO BOX 1451                      Specialty:
        City:  BENNINGTON                           Type: RADIOLOGY
       State:  VERMONT                Participation Code: ALL OTHER PARTICIPANT
         ZIP:  05201                  Medicare ID Number:
      County:  BENNINGTON                        Chain:
       Phone:  1-800-258-3599
         Fax:
 Type (FPDS):
 Austin Name:  RADIOLOGY ASO BENN INC
 Last Change                              Last Change
   TO Austin:                               FROM Austin:  11/18/93

Want to Edit data? NO// <RET>

Vendor has no prior payments for this patient

Want a new Invoice number assigned? YES// <RET>

Invoice # 2231 assigned to this Invoice
Enter Date Correct Invoice Received or Last Date of Service
(whichever is later): t-10  (APR 26, 2003)

Enter Vendor Invoice Date: t-11  (APR 25, 2003)

PATIENT ACCOUNT NUMBER: 4753822
Is this an EDI Claim from the FPPS System? YES

FPPS Claim ID: 1234


The answer to the following will apply to all payments entered via this option.
Are payments for contracted services? No//   NO

Enter date to use for CPT checks and fee schedule calc:  TODAY// <RET> (MAY 06, 2003)

Select Service Provided:    98940     CHIROPRACTIC MANIPULATION

Current list of modifiers: none
Select CPT MODIFIER: <RET>

Major Category: MEDICINE
  Sub-Category: CHIROPRACTIC MANIPULATIVE TREATMENT
      Procedure: 98940   CHIROPRACTIC MANIPULATION
```

```
                    Detail Description
                    ==================
CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

CODE TEXT MAY BE INACCURATE
Is this correct? YES// <RET>

REVENUE CODE: <RET>

UNITS: 1// <RET>

SITE OF SERVICE ZIP CODE: 05201// 05201

Select ICD DIAGNOSIS:    724.1     PAIN IN THORACIC SPINE
         ...OK? Yes//   (Yes)

Select PLACE OF SERVICE: 11       OFFICE
Select TYPE OF SERVICE: <RET>

Service connected condition? NO

Amount Claimed:  $: 50

Is $50 correct for Amount Claimed? Yes//   YES
  Fee schedule amount is $23.52 from the 2003 RBRVS FEE SCHEDULE
Amount Paid: $: 23.52// 23.52

Is $23.52 correct for Amount Paid? Yes//   YES

Up to 2 adjustment reasons can be specified.
Select ADJUSTMENT REASON: 119  Benefit maximum for this time period has been reached.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 1.45// 1.00

Select ADJUSTMENT REASON: 42  Charges exceed our fee schedule or maximum allowable
amount.
  ADJUSTMENT GROUP: CO  Contractual Obligation
  ADJUSTMENT AMOUNT: 0.45// <RET>



REMITTANCE REMARK: MA125  Per legislation governing this program, payment constitutes
payment in full.
REMITTANCE REMARK: <RET>


Date of Service: t-20  (APR 16, 2003)
Is 4/16/03 correct? Yes//   YES
```

FPPS LINE ITEM: *1*

```
       CHIROPRACTIC MANIPULATION      ....OK, DONE....
Invoice: 2231 Totals: $ 23.52


Date of Service: t-19  (APR 17, 2003)
Is 4/17/03 correct? Yes//   YES
```

FPPS LINE ITEM: *2*

```
       CHIROPRACTIC MANIPULATION      ....OK, DONE....
Invoice: 2231 Totals: $ 47.04


Date of Service: t-18  (APR 18, 2003)
Is 4/18/03 correct? Yes//   YES
```

FPPS LINE ITEM: *3*

```
       CHIROPRACTIC MANIPULATION      ....OK, DONE....
Invoice: 2231 Totals: $ 70.56
```

SUPERVISOR MAIN MENU
FPPS Update & Transmit Menu
Transmit Invoices to FPPS

FBAASUPERVISOR - required to access this option.

Introduction

This is a new function, which can be used to transmit invoices to the FPPS system.

This command can be run for either a specific **VistA Fee Basis** invoice number, or for all invoices in the queued state.

Example

```
SELECT FPPS UPDATE & TRANSMIT MENU OPTION: TRANSMIT INVOICES TO FPPS
THIS OPTION TRANSMITS HL7 MESSAGES TO FPPS FOR EDI INVOICES.

     SELECT ONE OF THE FOLLOWING:

          I         BY SPECIFIED INVOICE
          A         ALL PENDING INVOICES

SELECT TRANSMISSION OPTION: I  BY SPECIFIED INVOICE
SELECT FPPS QUEUED INVOICES INVOICE NUMBER:63989  162 (OUTP)     TRANSMITTED
DO YOU WANT TO RE-TRANSMIT INVOICE 63989? Y  YES
INVOICE HAS BEEN TRANSMITTED TO THE HL7 PACKAGE.


SELECT FPPS QUEUED INVOICES INVOICE NUMBER:
```

SUPERVISOR MAIN MENU
FPPS Update & Transmit Menu
Report of Transmissions to FPPS

 FBAASUPERVISOR - required to access this option.

Introduction

This is a new inquiry function, which can be used to view any transmissions made to the FPPS system and their status.

This report can be run to view transmissions during a specific date range and listed by invoice type.

Example

```
Select FPPS Update & Transmit Menu Option: rep ort of Transmissions to FPPS
This option generates a report of transmissions to FPPS for a date range.

From Date:  t-2  (SEP 13, 2003)
To Date: t  (SEP 15, 2003)
DEVICE: HOME//  <RET> VIRTUAL CONNECTION    Right Margin: 80// <RET>


FPPS Transmission Report                          SEP 15, 2003@15:26:26  page 1
  For Sep 13, 2003 through Sep 15, 2003
------------------------------------------------------------------------------

SUMMARY OF EDI INVOICES TRANSMITTED TO FPPS

                              ------------- Transmission Counts -------------
                              Payment    Payment               Accepted by
Station  Invoice Type         Confirmed  Cancelled  Total      Interface Eng.
-------  ------------         ---------  ---------  ---------  --------------

 605     Outpatient/Ancillary         0          1          1               0
                              ---------  ---------  ---------  --------------
 605 Station Totals                   0          1          1               0

                              =========  =========  =========  ==============
Report Totals                         0          1          1               0
```

MEDICAL FEE
Supervisor Menu
Audit Report for FPPS


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Introduction

This is a new inquiry function, which can be used to view certain types of changes made to existing FPPS Claims.

This audit report can be run for either a specific **VistA Fee Basis** invoice number, or for all changes made during a specific date range.

Example

```
        Outpatient/Ancillary Invoice Edit
          Pharmacy Invoice Edit
          Inpatient Invoice Edit
          Audit Report for FPPS Data
          Transmit Invoices to FPPS
          Report of Transmissions to FPPS
          Purge Message Text

Select FPPS Update & Transmit Menu Option: AUDit Report for FPPS

    Select one of the following:

          I         Invoice
          D         Date Range

Report one invoice or report by Date Range: Date Range// d  Date Range
From Date:  Sep 01, 2003//   (SEP 01, 2003)
To Date: Sep 30, 2003//   (SEP 30, 2003)
DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//
```

```
Date/Time Changed  File    IENS                              User
--------------------------------------------------------------------------------

 9/10/03@10:51:13  162.03  1,1,1520,10025225,                 ANTHONY,MARY A
    Field: FPPS CLAIM ID   Old Field Value: 2223
    Invoice: 63916         New Field Value: 465323
    Patient: HAASEL,DANNY LEE           Vendor: CHARLES MCCRAY JR LMFCC
    Date of Service: JUN 01, 2003   Service Provided: 11740

 9/10/03@10:57:35  162.03  1,1,1262,10025225,                 ANTHONY,MARY A
    Field: FPPS CLAIM ID   Old Field Value: 8876
    Invoice: 63917         New Field Value: 784934
    Patient: HAASEL,DANNY LEE           Vendor: NANCY A JONES D O
    Date of Service: JUN 01, 2003   Service Provided: 11055
Enter RETURN to continue or '^' to exit:


FPPS Data Audit Report by Date Range             SEP 15, 2003@14:53:42  page 3
  For Sep 01, 2003 through Sep 30, 2003

Date/Time Changed  File    IENS                              User
--------------------------------------------------------------------------------

 9/10/03@11:10:03  162.03  1,1,1617,11898,                    ANTHONY,MARY A
    Field: FPPS CLAIM ID   Old Field Value: 7299922
    Invoice: 63909         New Field Value: 2299927
    Patient: NANA,CLINTON              Vendor: RIVERSIDE CARDIOLOGY ASSOCIATE
    Date of Service: MAY 01, 2003   Service Provided: 10120

 9/10/03@11:10:35  162.03  1,1,1617,11898,                    ANTHONY,MARY A
    Field: FPPS LINE ITEM  Old Field Value: 1
    Invoice: 63909         New Field Value: 10
    Patient: NANA,CLINTON              Vendor: RIVERSIDE CARDIOLOGY ASSOCIATE
    Date of Service: MAY 01, 2003   Service Provided: 10120
Enter RETURN to continue or '^' to exit:

FPPS Data Audit Report by Date Range             SEP 15, 2003@14:53:42  page 4
  For Sep 01, 2003 through Sep 30, 2003
```

MEDICAL FEE
Supervisor Menu
Purge Message Text


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Introduction

This is a new inquiry function, which can be used to view certain types of changes made to existing FPPS Claims.

Example

```
Select FPPS Update & Transmit Menu Option: PURge Message Text
When an invoice is transmitted to FPPS via the HL7 package, a copy of the HL7
message text is saved in the FPPS QUEUED INVOICES (#163.5) file.

This option purges the message text for invoices transmitted prior to a
specified date.  Messages that have not been accepted by the VistA Interface
Engine will not be purged unless there is a later message for the same
invoice number that has been accepted.

Purge text of messages transmitted prior to:  7/17/03// 5/15/2003  (MAY 15, 2003
)
DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


FPPS Message Text Purge                          SEP 15, 2003@14:56:21  page 1
  For Messages Transmitted Prior To May 15, 2003
-------------------------------------------------------------------------------
Starting Purge...
Purge Completed.

The message text was purged from 0 entries in file 163.5.
Enter RETURN to continue or '^' to exit:
```

MEDICAL FEE
Vendor Menu
Payment Look-up for Medical Vendor


New Prompts:

Patient Control Number - This could be either the Patient Identification Number or Patient Account Number from the vendor's invoice.
FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Covered Days: This is the number of total number of Inpatient days that the Fee Staff has determined will be paid.
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Units Paid: Units of service being paid for this line item if any payment is being made for the line item. If payment is disapproved for the line item, enter the units of service that were billed Defaults to one (1) unit**.**
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.
Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Only one (1) Remittance Remark can be used for each Civil Hospital inpatient claim.

Introduction

The Payment Look-up for Medical Vendor option is used to view the payment history for a medical vendor for a specified time frame.

Example

```
                  ** VENDOR LOOK-UP **

                       Vendor: ACUTE CARE SPECIALISTS INC
              ('*' Reimb. to Patient  '+' Cancel. Activity)
PATIENT       ('#' Voided Payment)
  SVC DATE  CPT-MOD   REV.CODE UNITS  PATIENT ACCOUNT NO.   INVOICE #  BATCH #
    AMT CLAIMED  AMT PAID     ADJ CODE  ADJ AMOUNT      REMIT REMARK  DATE PAID
--------------------------------------------------------------------------------

FEEPATIENT,FEE A
* 06/15/01  99214                                              1943       1324
    $  300.00    $   56.50    1         $243.50                          NOT PAID
  06/15/01  G0154                                              1943       1368
    $   20.00    $   20.00              $0.00                            NOT PAID
# 05/20/01  99213                                              2142       1557
    $  200.00    $   45.00    1         $155.00                          NOT PAID
FEEPATIENT,MST B
  11/20/02  99361     190      1      604324567-1              2324       1692
    $  100.00    $   80.00    B13       $20.00           MA125,N45     07/17/03
     FPPS Claim ID: 1           FPPS Line Item: 4
    >>>Check # 81212127  Date Paid:  7/17/03<<<
  11/15/02  40830-26  110      2                              2325       1692
                -53
    $  200.00    $  129.66    4,B13     $20.34,50.00     M17,M1        07/14/03
     FPPS Claim ID: 50432       FPPS Line Item: 1
    >>>Check # CC212127  Date Paid:  7/14/03<<<
* 04/11/01  99213-52                                           1901       1308
    $   20.00    $   20.00              $0.00                            07/16/03
    >>>Check # 1212127  Date Paid:  7/16/03<<<
* 04/04/01  99213                                              1901       1308
    $   80.00    $   48.84    1         $31.16                           07/16/03
    >>>Check # 1212127  Date Paid:  7/16/03<<<
```

PHARMACY
Batch Menu - Pharmacy
List Items in Batch


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The List Items in Batch option is used to view all payment records in a selected batch. Your name can be entered at the first prompt, "Select FEE BASIS BATCH NUMBER", to list all your open batches.

Example

```
Select FEE BASIS BATCH NUMBER: 11          C93004
DEVICE: HOME//   FEE BASIS PRINTER    RIGHT MARGIN: 80// <RET>

Patient Name ('*' Reimbursement to Patient   '+' Cancellation Activity)
             ('#' Voided Payment)         Batch #  Voucher Date
   Vendor Name                   Vendor ID  Invoice #     Date Rec'd.
 RX  DATE   RX #     DRUG NAME             FPPS CLAIM  FPPS LINE
 CLAIMED          PAID     ADJ CODE  ADJ AMT
=====================================================================
MOORE,PETER            585-14-7544           11       6/4/94
   FAY'S DRUGS                   234324323     8          3/12/94
   3/13/94   12312333    ELAVIL           4321        1
   25.00          23.00    45         2.00

               INVOICE #: 8   TOTALS: $ 23.00

Select FEE BASIS BATCH NUMBER:
```

PHARMACY
Display Pharmacy Invoice


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.
Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.

Introduction

This option is used to view all the items in a Pharmacy invoice. The amount of data displayed will depend on the status of the invoice and the prescriptions on that invoice.

Example

```
Select FEE BASIS PHARMACT INVOICE NUMBER: 2346

  NUMBER: 2346
  DATE CORRECT INVOICE RECV'D: JUL 06, 2003
  DATA ENTRY CLERK: CLERK, FEE A     VENDOR: BILL'S DRUG STORE
  INVOICE STATUS: COMPLETED             TOTAL AMOUNT CLAIMED: 45
```

```
TOTAL AMOUNT PAID: 15.7                DATE INVOICE ENTERED: JUL 16, 2003
TOTAL LINE COUNT: 2                    VENDOR INVOICE DATE: JUL 04, 2003 FPPS CLAIM ID:
532423

PRESCRIPTION NUMBER: 6969593             DRUG NAME: AMOXACILLIN

DATE PRESCRIPTION FILLED: JUL 11, 2003
 AMOUNT CLAIMED: 20                     PATIENT: JONES,BARNABY
RED BOOK COST: 5.50                    AMOUNT SUSPENDED: 11.9
SUSPEND CODE: 4                        LINE ITEM STATUS: COMPLETED  GENERIC DRUG:
AMOXACILLIN 250MG CAP
PHARMACY DETERMINATION: APPROVED FOR PAYMENT
STRENGTH: 250MG                        QUANTITY: 30
PHARMACIST: SMITH, JOHN A              DATE OF DETERMINATION: JUL 16, 2003  AMOUNT PAID:
8.1                       BATCH NUMBER: 1700
OBLIGATION NUMBER: C95003              DATE CERTIFIED FOR PAYMENT: JUL 16, 2003
PAYMENT TYPE CODE: VENDOR              SUBSTITUTE GENERIC DRUG: Yes SUSPENSION
DESCRIPTION:  Claim/service rejected at this time because  information from another
provider was not provided or was  insufficient/incomplete.
PRIMARY SERVICE FACILITY: ALBANY       AUTHORIZATION POINTER: 1
FPPS LINE ITEM: 1
ADJUSTMENT REASON: 148                   ADJUSTMENT GROUP: CO
ADJUSTMENT AMOUNT: 11.9
REMITTANCE REMARK: MA125
REMITTANCE REMARK: N45
```

PHARMACY
Edit Pharmacy Invoice

 New Prompts:

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.

 FBAASUPERVISOR - required to edit payments from batches that have been released by a supervisor.

FBAA ESTABLISH VENDOR - required to enter a new vendor.

Introduction

The Edit Pharmacy Invoice option is used to edit data from a previously entered Pharmacy invoice. All data contained on the invoice may be edited (with the

exception of the invoice number). Payments from batches that have been finalized cannot be edited.

Example

```
Select Invoice #:  38
DATE CORRECT INVOICE RECV'D: SEP 17,1994//  <RET>
VENDOR INVOICE DATE: SEP 14,1994//  <RET>
Is this an EDI claim frm the FPPS system? YES// <RET>
FPPS CLAIM ID: 4321//
VENDOR: BARNABY DRUGS//  <RET>
INVOICE STATUS: PENDING PAYMENT PROCESS//  <RET>
Select PRESCRIPTION NUMBER: 55303    DATE RX FILLED: 05/01/94

PRESCRIPTION NUMBER: 55303//  <RET>
FPPS LINE ITEM: 1// <RET>
DRUG NAME: VALIUM//  <RET>
STRENGTH: 5MG//  10MG
QUANTITY: 30//  20
AMOUNT CLAIMED: 21//  <RET>
RED BOOK COST: 15//  <RET>
AMOUNT PAID: 18.25//  <RET>
Current list of Adjustments: Code: 119     Group: OA   Amount: $20.00
Select ADJUSTMENT REASON: <RET>
Current list of Remittance Remarks: MA125,
REMITTANCE REMARK: MA125// <RET>
REMITTANCE REMARK: <RET>
LINE ITEM STATUS: PENDING PAYMENT PROCESS//  <RET>

Select Invoice #:
```

PHARMACY
Enter Pharmacy Invoice

 New Prompts:

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.

FPPS Claim ID: 1-32 character text ID created by FPPS system.

FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.

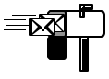
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.

 FBAA ESTABLISH VENDOR - required to enter new vendors.

 New insurance information may be uploaded into IB files through this option.

 A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.

Introduction

The Enter Pharmacy Invoice option is used to enter Pharmacy invoices into the system for payment. If you are entering a new invoice, the system will automatically assign a new invoice number. If you are continuing with a previously entered invoice, the system will display the line items that have already been entered, if requested. Each invoice is made up of individual prescriptions. The prescription data, including date prescription filled, prescription number, drug name, strength, and quantity is entered separately for each prescription. The invoice is not assigned to a batch in this option but at a later time in the Pharmacy invoice payment process.

At most facilities, both MAS and Pharmacy Service are involved. The system automatically refers the prescription to Pharmacy Service for a determination.

Duplicate entry of prescription numbers filled on the same date for the same vendor will not be allowed. The system will alert you to the duplicate entry.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

Example

```
Are you sure you want to enter a new invoice? Yes// <RET>

Invoice # assigned is: 599

Select FEE BASIS VENDOR NAME: CVS     345658976  CHAIN #: 101  PHARMACY
          123 MAIN AVE                  (Awaiting Austin Approval)
          TROY, NY  12180    TEL. #:  518-272-0987


                     ***  VENDOR DEMOGRAPHICS  ***
                   ==> AWAITING AUSTIN APPROVAL <==

        Name:  CVS                              ID Number: 345658976
     Address:  123 MAIN AVE                     Specialty:
        City:  TROY                                  Type: PHARMACY
       State:  NEW YORK               Participation Code: PHARMACY
         ZIP:  12180                  Medicare ID Number: 181818
      County:  RENSSELAER                          Chain: 101
       Phone:  518-272-0987
         Fax:  518-272-0900
 Austin Name:
 Last Change                                Last Change
   TO Austin: 11/21/94                         FROM Austin:
```

```
Want to edit Vendor data? No// <RET>

Date Correct Invoice Received: 11/30  (NOV 30, 1994)

Vendor Invoice Date:  11/25  (NOV 25, 1994)
Is this an EDI Claim from the FPPS system? YES
FPPS Claim ID: 4321
FPPS Line Item: 1

Select Patient: DAY,DENNIS           07-21-50     409129012     NSC VETERAN


DAY,DENNIS                              Pt.ID: 409-12-9012
129 BROWNDYKE ROAD                        DOB: JUL 21,1950
COHOES                                    TEL: 518-261-8911
NEW YORK 12901                         CLAIM #: Not on File
                                        COUNTY: COLUMBIA

Primary Elig. Code: NSC  --  PENDING VERIFICATION  JUL 15, 1987
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED

  Service Connected: NO
 Rated Disabilities: NONE STATED
    Health Insurance: NO
    Insurance Co.     Subscriber ID   Group Holder  Effective Expires
=========================================================================No
Insurance Information
Want to add NEW insurance data? No//<RET>
Are there any discrepancies with insurance data on file? No//<RET>

Patient Name: DAY,DENNIS                                 Pt.ID: 409-12-9012

AUTHORIZATIONS:
   (1) FR: 08/30/94      VENDOR: DOOLY MEDICAL CENTER - 777999098
       TO: 09/17/94
                        Authorization Type: CIVIL HOSPITAL
Purpose of Visit: EMERG. NON-VA CARE (INPT/OPT) VET. REC. CARE IN FED. HOSP.
AT VA EXP.
           DX:
       County: COLUMBIA                PSA: ALBANY, NY

           REMARKS:
              7078 DEFAULT AUTH SERVIC TEXT
   (2) FR: 11/01/94      VENDOR: CVS - 345658976
       TO: 12/31/94
                        Authorization Type: Outpatient - Short Term
         Purpose of Visit: OPT TO OBVIATE THE NEED FOR HOSP. ADMISSION
           DX:
       County: COLUMBIA                PSA: ALBANY, NY

Enter a number (1-3): 2
Want to review fee pharmacy payment history? No// <RET>


DATE PRESCRIPTION FILLED: 11/15  (NOV 15, 1994)
```

```
Select PRESCRIPTION NUMBER: 12345
  AMOUNT CLAIMED: 65.00
  DRUG NAME: VALIUM
  MANUFACTURER: ROCHE
  STRENGTH: 5MG
  QUANTITY: 100

Prescription referred to Pharmacy Service for determination.

Select Patient: <RET>

Invoice No.: 599 Completed!

Want to enter another Invoice? No// <RET>
```

PHARMACY
Review Fee Prescription

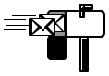
New Prompts:

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.


A YES response at the "Are there any discrepancies with insurance data on file?" prompt generates a mail bulletin to MCCR to report erroneous insurance data.


New insurance information may be uploaded into IB files through this option.

Introduction

The Review Fee Prescription option allows review of a fee basis prescription by Pharmacy Service. This review is to determine if the prescription was for a service-connected disability, if it was required in an emergent situation, and whether or not payment should be based on the generic drug price. The review is usually made by a pharmacist. If the drug was not prescribed for an authorized condition in an emergent situation, it will be disapproved for payment, and the vendor will be notified through a suspension letter.

New insurance information may be entered through this option. For help with entering new insurance data and/or reporting discrepancies in current information for the selected patient to MCCR, please refer to Appendix A.

It should be noted that if the VA generic drug equivalent is not entered when reviewing a prescription, the system will act as if that prescription has not been reviewed. The prescription will remain in a PENDING PHARMACY DETERMINATION status.

Example

```
 ...HMMM, I'M WORKING AS FAST AS I CAN...

There are 2 Fee Prescription(s) Pending Pharmacy review

Want to review some now? Yes//  <RET>
Select FEE BASIS PHARMACY INVOICE NUMBER:  199

JONES,MICKEY                          Pt.ID: 606-77-8899
2233 LOOKOUT RD                        DOB: JUN 12,1955
TACOMA                                     TEL: Not on File
WASHINGTON 98493                       CLAIM #: 5557788
                                        COUNTY: THURSTON

Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  MAY 14, 1993
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED
 SC Percent: 100%
 Rated Disabilities: PSYCHOSIS (50%-SC)
                     SEIZURE DISORDER (40%-SC)
                     ARTERIOSCLEROSIS (30%-SC)
                     TINNITUS (0%-SC)

    Health Insurance: NO
    Insurance Co.     Subscriber ID     Group       Holder  Effective Expires
    ========================================================================
    No Insurance Information
Want to add NEW insurance data? No// <RET>
Are there any discrepancies with insurance data on file? No// <RET>
Fee ID Card #: 777777                   Fee Card Issue Date: 11/15/92

Patient Name: JONES,MICKEY                          Pt.ID: 606-77-8899

AUTHORIZATIONS:
   (1) FR: 07/01/93      VENDOR: SUNNY ACRES - 225447788
       TO: 07/15/94
                         Authorization Type: CONTRACT NURSING HOME
Purpose of Visit: COMMUNITY NURSING HOME FOR SC DISABILITY(IES)
           DX:
       County: THURSTON                 PSA: TACOMA (AMERICAN LAKE), WA
           REMARKS:


Want to review fee pharmacy payment history? No// <RET>
------------------------------------------------------------------------

Vendor: BROOKS PHARMACY
```

```
Prescription #: 346056    Drug: IBUPROFEN

Fill Date: 07/13/93    Strength: 350MG  Qty: 30
Is Prescription for an Authorized Condition? Yes// <RET>
Was a Generic Drug issued to patient? Yes// <RET>
Enter VA Generic Drug equivalent: diazepam
     1   DIAZEPAM 10MG S.T.
     2   DIAZEPAM 10MG SYRINGE                    10-24-82
     3   DIAZEPAM 2MG S.T.
     4   DIAZEPAM 5MG TAB
     5   DIAZEPAM 5MG/ML 10ML MDV                  N/F
TYPE '^' TO STOP, OR
CHOOSE 1-5: 4
Is this an emergency medication? Yes//  <NO>
Current list of Adjustment Reasons: None
Select ADJUSTMENT REASON: 40 Charges do not meet qualifications for
emergent/urgent care
ADJUSTMENT GROUP: PR Patient Responsibility
ADJUSTMENT AMOUNT: 20.00
Current list of Adjustment Reasons: 40 Group: PR Amount: 20
Select ADJUSTMENT REASON: <RET>
Current list of Remittance Remarks: None
REMITTANCE REMARK: <RET>

Optional Pharmacy Remarks:
Optional Pharmacy Remarks: MEDICATION LOST IN MAIL
--------------------------------------------------------------------------
                      >>>  PRESCRIPTION REVIEW  <<<

Rx for Authorized condition: Yes     Emergency Medication: Yes
Generic Drug Issued: Yes               Generic Drug Name: DIAZEPAM

Optional Pharmacy Remarks: MEDICATION LOST IN MAIL

Want to edit prior to release? No// <RET>

Want to review another Prescription? Yes//NO
```

PHARMACY
Complete Pharmacy Invoice


New Prompts:

Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.

Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.

Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.

Introduction

The Complete Pharmacy Invoice option is used to enter the remaining payment data for those items within the invoice which required a determination by Pharmacy service. (MAS must enter the remaining data prior to closeout). These items may include the following:

- Red Book cost
- Amount paid
- Amount suspended
- Suspense code (if applicable)

The Red Book is an annual pharmacists' reference containing dosage tables, drug interactions, product information, and available prices.

Example

```
Select FEE BASIS PHARMACY INVOICE NUMBER:  234


Vendor: GRETLE PHARMACY     Vendor ID: 888888888

Patient: TUTTLE,BARBARA    Patient ID: 090-90-0090

Drug Name                  RX #   Strength    Qty   Amt Claimed
============================================================
VALIUM                     987      25MG      30       20
MEDICAID DISPENSING FEE: $3.25// <RET> 3.25


RED BOOK COST:  12.00// <RET>
AMOUNT PAID: 15.25//  <RET>
Current list of Adjustments: None
Select ADJUSTMENT REASON: 119 Benefit maximum for this time period has been
reached.
ADJUSTMENT GROUP: CO Contractual Obligation
ADJUSTMENT AMOUNT: 2.00// <RET>
Current list of Adjustments: 119  Group: CO  Amount: 2.00
Select ADJUSTMENT REASON: 42 Charges exceed our fee schedule or maximum
allowable amount.
ADJUSTMENT GROUP: CO Contractual Obligation
ADJUSTMENT AMOUNT: 2.25// <RET>
Current list of Remittance Remarks: None
REMITTANCE REMARK: MA125 per legislation governing this program, payment
constitutes payment in full.
Current list of Remittance Remarks: MA125,
REMITTANCE REMARK: <RET>

Invoice is Complete            Totals $15.25

Select FEE BASIS PHARMACY INVOICE NUMBER:
```

PHARMACY
List Pharmacy History


New Prompts

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Group: The Adjustment Group Code pertains to the previously entered adjustment reason code. There are only 5 acceptable HIPAA Adjustment Group Codes to select from. This grouping code pertains to the previously entered adjustment reason code. One (1) Adjustment Group code must be associated with each Adjustment Reason code that is entered in VistA Fee Basis.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.
Remittance Remark: Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Two Remittance Remarks can be used for each Pharmacy claim.

Introduction

The List Pharmacy History option is used to display or print a list of all the Fee Basis prescriptions for a selected patient. These are listed in reverse chronological order, with the most recent date first. Reimbursements to the patient, voided payments, and cancellation activity are indicated.

Example

```
Select FEE BASIS PATIENT NAME:  TERRANTON,ADAM    10-18-20   111111111
DEVICE: HOME//  <RET>                 RIGHT MARGIN: 80// <RET>


Patient: TERRANTON,ADAM            SSN: 111111111    DOB: 10/18/20

('*'Re-imbursement to Patient '+'Cancellation Activity)('#' Voided Payment)
  Vendor Name                                      ID #       Chain #
    Fill Date
          Drug Name                         Strength        Quantity
  Claimed  Paid   Adj Code  Adj Amount Invoice # Batch # Remit Remark
=====================================================================
VACHON PHARMACY                                    878787878
    04/01/94
 Rx: 900     LASIX                          250MG              30
    12.00    10.00  4,6    1.00,1.00   352      109     MA125, N45
    FPPS Claim ID: 321   FPPS Line Item: 1

VACHON PHARMACY                                    878787878
    03/23/94
 Rx: 509         VALIUM                        10MG              15
    6.00       6.00                       352      109
    FPPS Claim ID: 123  FPPS Line Item: 1

FAYS DRUGS                                         123987789    309
    12/02/93
 Rx: 321         MEPROBAMATE                   400MG              30
    13.00     3.00    45      10.00     265      98      M118, N1
    FPPS Claim ID: 3456 FPPS Line Item: 1
```

PHARMACY
Check Display


New Prompts

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Two Adjustment Reasons can be used for each Pharmacy claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example

```
Select Check Number: 22936
                      PAYMENT HISTORY FOR CHECK # 22936
                    --------------------------------         Page: 1

                      FEE PROGRAM:  PHARMACY
('*' Reimbursement to Patient '#' Voided Payment '+' Cancellation Activity)
   Fill Dt   RX #                                  Batch #     Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
========================================================================

VENDOR:  HOMETOWN PHARMACY          VENDOR ID:  953522679

Patient:  FEEPATIENT, HENRY A            Patient ID:  999-49-9999
   4/6/03    76584                                    22011    63922
         20.00       20.00             0.00
```

```
          FPPS Claim ID: 476895       FPPS Line Item: 1
   >>>Check # 22936  Date Paid:  9/8/03<<<
  4/6/03    896743                                        22011    63922
       15.00       10.00   45        5.00
          FPPS Claim ID: 476895       FPPS Line Item: 3
   >>>Check # 22936  Date Paid:  9/8/03<<<
```

PHARMACY:
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

Example

```
FPPS CLAIM ID: 9809

FPPS Claim Inquiry for ID: 9809                       SEP 11,2003
Page 1
--------------------------------------------------------------------------------
Pharmacy Invoice: 63757
Enter RETURN to continue or ^ to exit:
```

UNAUTHORIZED CLAIM
Enter/Edit Unauthorized Claim Menu
Enter Unauthorized Claim


New Prompts:

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.
FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction

This option is used to enter an unauthorized claim for payment of unauthorized inpatient charges. An unauthorized claim is one where an eligible veteran has received inpatient treatment from a civil hospital or private provider and VA was not notified within the proper time frame. Unauthorized claims may be entered for any Fee Basis program.

NOTE: If the Fee Basis program is Contract Nursing Home, the claim is automatically dispositioned as DISAPPROVED with a disapproval reason of NON-EMERGENT CARE.

A claim is considered complete when VA Form 10-583, Claim for Payment of Cost of Unauthorized Medical Services, and all required documentation has been received in order to determine legal and medical entitlement. A claim can never be considered complete if it is missing VA Form 10-583 or if the form is incomplete. Other required documentation includes the following:

- Copies of actual bills
- Original paid receipt
- Itemized invoice/UB82
- Medical records or signature for release
- Diagnostic/Procedure code(s)

If you have indicated that you will be tracking incomplete claims in your FEE BASIS SITE PARAMETERS file (#161.4), you may enter an incomplete claim. Incomplete claims are automatically given a status of INCOMPLETE UNAUTHORIZED. If you have not entered anything in the parameter, you may only enter complete unauthorized claims. (Refer to Appendix B for more information about statuses.)

If the "Initial Entry" Status for the U/C field in the FEE BASIS SITE PARAMETERS file (#161.4) is filled in, then minimum data is required for entering an unauthorized claim. This is designed for sites who have streamlined their workload, where only one user enters in the unauthorized claims received, and another reviews the claim for completeness and makes the necessary requests, etc.

You can associate the new claim with an existing claim. If you associate the new claim with a previously entered claim or group of claims, and at least one of those claims has been dispositioned, you are asked if you wish to disposition the new claim to the same disposition. When claims are associated, they are displayed with the primary claim on lookup, and, in certain instances, you have the ability to update all the claims in the group at the same time.

Example

```
Select Enter/Edit Unauthorized Claim Menu Option:  ENTer Unauthorized Claim


Select VETERAN:    FEEPATIENT,FEE A        3-15-40    405345678           SC VET
ERAN
Select FEE VENDOR:    RADIOLOGY ASO BENN INC.  030226493  ALL OTHER PARTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599

Select FEE BASIS PROGRAM NAME: OUTPATIENT
Is this an EDI Claim from the FPPS System? YES
FPPS Claim ID: 1234
Is this claim being considered under Millennium Act 38 U.S.C. 1725 (Y/N)? NO
TREATMENT FROM DATE: T-10  (APR 28, 2003)
TREATMENT TO DATE: 4/28/03// <RET>  (APR 28, 2003)
Is the unauthorized claim complete for the FEE PROGRAM? YES
Checking for potential duplicates...


Checking eligibility...


Primary Elig. Code: SERVICE CONNECTED 50% to 100%  --  VERIFIED  SEP 05, 2000
Other Elig. Code(s): NO ADDITIONAL ELIGIBILITIES IDENTIFIED


Are you sure you wish to enter a new unauthorized claim? YES
CLAIM SUBMITTED BY: RADIOLOGY ASO
```

```
     Searching for a Patient


     Searching for a Vendor
  RADIOLOGY ASO BENN INC.               030226493  ALL OTHER PARTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599

        ...OK? Yes// <RET>  (Yes)
DATE CLAIM RECEIVED: MAY 8,2003//
DIAGNOSIS: DIAG
PRIMARY SERVICE FACILITY:    ALBANY  NY  VAMC  500
AMOUNT CLAIMED: 100
TREATING SPECIALTY: MED  MEDICAL
DISPOSITION:
DISPOSITION REMARKS:
  1>


Select VETERAN:
```

UNAUTHORIZED CLAIM
Enter/Edit Unauthorized Claim Menu
Modify Unauthorized Claim

 New Prompts:

Is this an EDI Claim from the FPPS system? - 1-32 character text ID created by FPPS system. Answering NO indicates that all line items within the invoice will NOT be for an EDI (Electronic Data Interchange) Claim. Answering YES indicates that all of the line items within the invoice will be for an EDI Claim. Answering YES will result in an additional prompt appearing at the input of EACH line item.
FPPS Claim ID: 1-32 character text ID created by FPPS system.

 FBAASUPERVISOR - required to change the disposition to a non-approved status.

Introduction

The Modify Unauthorized Claim option is used to edit only those unauthorized claims which were never dispositioned. To modify an unauthorized claim, you must first identify the submitter. The submitter may differ from the vendor or veteran involved with the claim. In such cases the submitter is considered an "other party".

Example

```
Select Enter/Edit Unauthorized Claim Menu Option: MODify Unauthorized Claim
Select unauthorized claim: V.RADIOLOGY A
     1   RADIOLOGY ASO BENN INC.        030226493  ALL OTHER PARTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599

     2   RADIOLOGY ASSN OF TAMPA        591433551  ALL OTHER PARTI
          PO BOX 31249
          TAMPA, FL  33631

     3   RADIOLOGY ASSO OF OCALA        591289802  ALL OTHER PARTI
          617 SE 17TH ST                (Vendor in Delete Status)
          OCALA, FL  34471

     4   RADIOLOGY ASSOC HOLLYWOOD PA    591226776  ALL OTHER PARTI
          PO BOX 4227
          HOLLYWOOD, FL  33023
```

```
     5   RADIOLOGY ASSOC OF KEENE       020361503  ALL OTHER PARTI
          151 WEST STREET
          KEENE, NH  03431    TEL. #:  800 872 2755


 Press <ENTER> to see more, '^' to exit this list, OR

CHOOSE 1-5: 1  RADIOLOGY ASO BENN INC.  030226493  ALL OTHER PARTI
          PO BOX 1451
          BENNINGTON, VT  05201    TEL. #:  1-800-258-3599




   Select from the following:



 1   RADIOLOGY AS   FEEPATIENT,F   OUTPATIENT       5/8/03     COMPLETE/PENDING
      TREATMENT FROM: 4/28/03    TREATMENT TO: 4/28/03

Enter selection:  (1-1): 1
DATE CLAIM RECEIVED: MAY 8,2003// <RET>
FEE PROGRAM: OUTPATIENT// <RET>
Is this an EDI Claim from the FPPS System? YES// <RET>
FPPS Claim ID: 1234// <RET>
38 U.S.C. 1725:
VENDOR: RADIOLOGY ASO BENN INC.// <RET>
VETERAN: FEEPATIENT,FEE A// <RET>
CLAIM SUBMITTED BY: RADIOLOGY ASO BENN INC.// <RET>
TREATMENT FROM DATE: APR 28,2003// <RET>
TREATMENT TO DATE: APR 28,2003// <RET>
DIAGNOSIS: DIAG// <RET>
PRIMARY SERVICE FACILITY: ALBANY// <RET>
AMOUNT CLAIMED: 100// <RET>
PATIENT TYPE CODE: MEDICAL//  <RET>
DISPOSITION: <RET>
```

UNAUTHORIZED CLAIM
Outputs for Unauthorized Claims
Check Display


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.
FPPS Line Item: Only asked if the user answered YES to the above prompt. It allows you to indicate the EDI Claim line item number for each service paid or denied. With EDI claims, every line item must eventually be accounted for.
Revenue Code: Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. During Phase One of the Fee Replacement project, both the Revenue Code and the CPT/HCPCS code must be entered when available.
Adjustment Reason: Adjustment reason codes explain why the amount paid differs from the amount claimed. The HIPAA term "Adjustment Reason" replaces the VistA Fee term "Suspend Code." Only 1 Adjustment Reason can be used for each Civil Hospital inpatient claim. Adjustment Reason code is now asked before the Adjustment Amount.
Adjustment Amount: Enter the dollar amount that is not being paid for this charge per the adjustment reason. The HIPAA term "Adjustment Amount" replaces the VistA Fee term "Amount Suspended." Adjustment Amount is now asked after the Adjustment Reason.

Introduction

The Check Display option displays all payments included on a check that was issued after the payment conversion from CALM (Centralized Accounting for Local Management) to FMS (Financial Management System). The information displayed may differ dependent upon the Fee Basis program you are using.

Example

```
          All Claims by Vendor/Veteran/Other
          Check Display
          Display Unauthorized Claim
          Disposition/Status Statistics Display/Print
          Expiration Display/Print
          FPPS Claim Inquiry
          Status Display/Print of Unauthorized Claims
          Unauthorized Claims Cost Report for Civil Hospital
          Vendor Payments Output
          Veteran Payments Output

Select Outputs for Unauthorized Claims Option: check Display

Select Check Number: 90936

DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


                    PAYMENT HISTORY FOR CHECK # 90936
                    ---------------------------------                  Page: 1

                      FEE PROGRAM:  OUTPATIENT
 ('*' Reimbursement to Patient  '#' Voided Payment  '+' Cancellation Activity)
   Svc Date  CPT-MOD   Rev.Code                            Batch #  Invoice #
   Amt Claimed   Amt Paid   Adj Code  Adj Amount
================================================================================

VENDOR:  RIVERSIDE CARDIOLOGY ASSOCIATES  VENDOR ID:  330470453

Patient:  NANA,CLINTON                Patient ID:  552-66-4444
   5/1/03    10120     314                                 21965    63909
       998.00      104.07   42        893.93
            FPPS Claim ID: 2299927      FPPS Line Item: 10
    >>>Check # 90936  Date Paid:  9/8/03<<<


Enter RETURN to continue or '^' to exit:

Select Check Number:
```

UNAUTHORIZED CLAIM
Outputs for Unauthorized Claims
Display Unauthorized Claim


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction

This option is used to view unauthorized claims. Selection is made by entering the name of the submitter. The submitter may be the vendor, veteran, or other party involved in the claim.

Example

```
DATE CLAIM RECEIVED: JUN 26, 2003          FEE PROGRAM: CIVIL HOSPITAL
  VENDOR: ALBANY MED CENTER                VETERAN: FEEPATIENT,FEE A
  TREATMENT FROM DATE: MAY 07, 2003        TREATMENT TO DATE: MAY 17, 2003
  PRIMARY SERVICE FACILITY: ALBANY         DATE VALID CLAIM RECEIVED: JUN 26, 2003
  AMOUNT CLAIMED: 1000                     PATIENT TYPE CODE: MEDICAL
  DISPOSITION: APPROVED TO STABILIZATION
  DATE OF DISPOSITION: JUN 26, 2003        AUTHORIZED FROM DATE: MAY 07, 2003
  AUTHORIZED TO DATE: MAY 10, 2003         PRINT LETTER?: YES
  ENTERED/LAST EDITED BY: BAUMANN,SCOTT A
  DATE ENTERED/LAST EDITED: JUN 26, 2003
  MASTER CLAIM: JUN 26, 2003
  DATE OF ORIGINAL DISPOSITION: JUN 26, 2003
  CLAIM SUBMITTED BY: ALBANY MED CENTER
  STATUS: DISPOSITIONED                    DATE OF CURRENT STATUS: JUN 26, 2003
  AUTHORIZATION: 70                        FPPS CLAIM ID: 12345
  DIAGNOSIS: BACK PAIN
  DISCHARGE TYPE (c): DISCHARGE

Enter RETURN to continue or '^' to exit:
```

UNAUTHORIZED CLAIMS
Output Menu
FPPS Claim Inquiry


New Prompts:

FPPS Claim ID: 1-32 character text ID created by FPPS system.

Introduction:

This is a new inquiry function, which can be used to cross reference FPPS Claim ID numbers to the corresponding VistA Fee Invoice Number.

EXAMPLE

```
Select Outputs Main Menu Option: fpps Claim Inquiry
FPPS CLAIM ID: 414
DEVICE: HOME//   VIRTUAL CONNECTION    Right Margin: 80//


FPPS Claim Inquiry for ID: 414                  SEP 17, 2003@09:33:02  page 1
--------------------------------------------------------------------------------
Outpatient/Ancillary Invoice: 63995
Enter RETURN to continue or '^' to exit:

FPPS CLAIM ID:
```

VISTA FEE BASIS – NEW PROMPTS
Help Text for FPPS Prompts

Introduction

For each new prompt listed, help text is available in the same two-level format that exists in the previous VistA Fee Basis documentation.

Help Text

Prompt	Level	Help Text
PATIENT CONTROL NUMBER:	1 (?)	Answer must be 1 to 20 characters in length.
	2 (??)	PLEASE ENTER THE PATIENT CONTROL NUMBER. THIS COULD BE EITHER THE PATIENT IDENTIFICATION NUMBER OR PATIENT ACCOUNT NUMBER FROM THE VENDOR'S INVOICE.
Is this an EDI Claim from the FPPS system?	1 (?)	Enter either 'Y' or 'N'.
	2 (??)	Must enter Yes or No to continue. If unsure, check to see if a FPPS Claim ID number on the invoice document. If yes, enter yes.
FPPS CLAIM ID:	1 (?)	Enter a non-zero number from 1 to 32 digits long, 0 decimal digits.
	2 (??)	Enter the entire FPPS Claim ID as shown on the invoice document. (1-32 character text ID created by FPPS system).
FPPS LINE ITEM:	1 (?)	This response must be a number or a list or range, e.g., 1,3,5 or 2-4,8.
	2 (??)	Enter the line item sequence number associated with this charge. Each charge on the FPPS invoice document will have a line item sequence number associated with it. A line item can be entered individually or a group of charges from multiple lines can be entered. If all line items in a group are in numerical sequence, you may enter the first line item sequence number followed by a hyphen and the last line item sequence number. If the grouped charges are not in sequential order, each line item must be entered individually, followed by a comma.

Prompt	Level	Help Text
COVERED DAYS:	1 (?)	Enter a number from 1 to 99999.
	2 (??)	This is the number of total number of Inpatient days that the Fee Staff has determined will be paid. Enter number of inpatient days to be paid.
REVENUE CODE:	1 (?)	Answer with the revenue code associated with this charge. Answer with REVENUE CODE, or STANDARD ABBREVIATION, or ACTIVATE, or DESCRIPTION Do you want the entire REVENUE CODE List? N (No)
	2 (??)	Revenue code is a 3-digit code associated with itemized charges on a UB92 billing invoice. A revenue code should be entered if a CPT/HCPCS code was not specified for the line item. If both revenue code and a CPT/HCPCS code have been entered for a line item, the revenue code will be considered the more accurate description of the service. Choose from: 100 ALL INCL R&B/ANC ALL-INCLUSIVE ROOM AND BOARD PLUS ANCILLARY 101 ALL INCL R&B ALL-INCLUSIVE ROOM AND BOARD 240 ALL INCL ANCIL GENERAL CLASSIFICATION
UNITS PAID:	1 (?)	Enter a number from 1 to 99999, 0 decimal digits.
	2 (??)	Units of service being paid for this line item if any payment is being made for the line item. If payment disapproved for the line item then enter the units of service that were billed.

Prompt	Level	Help Text
Select ADJUSTMENT REASON:	1 (?)	Select the a HIPAA Adjustment (suspense) Reason Code. Answer with ADJUSTMENT REASON CODE Do you want the entire ADJUSTMENT REASON CODE List? N (No)
	2 (??)	ADJUSTMENT REASON CODES EXPLAIN WHY THE AMOUNT PAID DIFFERS FROM THE AMOUNT CLAIMED. Choose from: A LIST IS SHOWN HERE
ADJUSTMENT GROUP:	1 (?)	Select the a HIPAA Adjustment Group Code. Answer with ADJUSTMENT GEOUP CODE Do you want the entire ADJUSTMENT GROUP CODE List? N (No)
	2 (??)	THE ADJUSTMENT GROUP CODE PERTAINS TO THE PREVIOUSLY ENTERED ADJUSTMENT REASON CODE. Choose from: A LIST IS SHOWN HERE
ADJUSTMENT AMOUNT:	1 (?)	Enter a Dollar Amount between .01 and 999999, 2 Decimal Digits
	2 (??)	ENTER THE DOLLAR AMOUNT THAT IS NOT BEING PAID FOR THIS CHARGE PER THE ADJUSTMENT REASON.
REMITTANCE REMARK:	1 (?)	Select the a HIPAA Remittance Remark Code. Answer with REMITTANCE REMARK CODE Do you want the entire REMITTANCE REMARK CODE List? N (No)
	2 (??)	Select a remittance remark code to provide non-financial information critical to understanding the adjudication of the claim. Choose from: A LIST IS SHOWN HERE